DEPARTMENT OF VETERANS AFFAIRS
Jack C. Montgomery
VA Medical Center
1011 Honor Heights Drive
Muskogee, OK 74401

In Reply Refer To: 623/00
2010 Facility Inspection

March 30, 2010

Cindy Adams, Administrator
Oklahoma Veterans Center
Claremore Division
3001 West Blue Starr Drive
Claremore, Ok 74018

Dear Ms. Adams:

The Jack C. Montgomery VAMC/Ascellon inspection team conducted the annual inspection of the Claremore Veterans Center March 9 through March 11, 2010. This letter will serve as an official notification of Provisional Certification for the State Home. The facility will remain provisionally certified until all standards have been rated as met. VA Form 10-3567b (State Home Inspection Standards) and supplemental attachments regarding the findings are enclosed.

The provisionally met/not met standards rated by the survey team are being submitted to Veterans Administration at Central Office as required. Additional comments/ recommendations may be forthcoming (via letter or email) following their review of the findings. You will receive copies of any information sent to the state home contact. Please incorporate any Central Office additions in your plan of correction. **Timeframes for annual reporting state: "The state home is required to provide a plan of corrective action 10 work days following receipt of the survey report."**

The following provisionally met standards were identified in the facility:

Not met standard:
51.210a – Administration

Provisional met standard:
51.210i – Medical Director

Provisional met standard:
51.210j – Credentialing & Privileging

Cindy Adams, Administrator, Claremore Vet Center
SUBJ: Annual Inspection

Not met standard:
51.210 p 2 – Quality Assessment and Assurance Committee

Provisional met standard:
51.90 a – Restraints

Provisional met standard:
51.90 c 2 – Abuse Investigating and Reporting

Provisional met standard:
51.100 h 4 – Social Service Crisis Intervention

Provisional met standard:
51.140 a – Annual assessment by the Registered Dietician

Not met standard:
51.140 d 3 – Thickened Liquids

The survey team will review the plan of correction, when received, to determine if actions to be taken will bring deficiencies into compliance with VA standards. If you have any questions, please contact Lindsey Alig, Geriatrics & Extended Care Administrative Officer, at 918-577-3830.

Sincerely,

BRIAN A. HAWKINS, MHA
Medical Center Director

Enclosures

TRANSMISSION VERIFICATION REPORT

TIME : 09/08/2010 14:33
NAME : HBPC
FAX : 918-781-8596
TEL : 918-781-8557
SER.# : BROH3J589305

DATE,TIME	09/08 14:32
FAX NO./NAME	93420835
DURATION	00:00:22
PAGE(S)	01
RESULT	OK
MODE	STANDARD ECM

Department of Veterans Affairs

VHA FAX TRANSMITTAL

To	Fax Number ☐ FTS	☐ Commercial	Date	No. Pages Attached
Cindy Adams, Administrator Oklahoma Vet Center - Claremore	(918) 342-0835		09/08/2010	0

Subject
Follow-up VA Inspection

From	Telephone Number ☐ FTS	☐ Commercial
Nicole Hall, Acting Administrative Officer Jack C. Montgomery VA Medical Center		(918) 577-3830

This transmission is intended only for the use of the person or office to whom it is addressed and may contain information that is privileged, confidential, or protected by law.

All others are hereby notified that receipt of this fax does not waive any applicable privilege or exemption from disclosure and that any dissemination, distribution, or copying of this communication is prohibited.

If you received this communication in error, please notify us immediately at the telephone number shown above. Thank you.

CIRCLE ALL THAT APPLY 1. URGENT 2. FOR REVIEW 3. PLEASE COMMENT

4. PLEASE REPLY 5. PLEASE RECYCLE AFTER REVIEW

The VA will be conducting a follow-up inspection for your facility, Thursday, September 09, 2010, based on initial inspection conducted on March 11, 2010. The Team should begin to arrive at approximately 0930hrs. Please arrange for adequate space for the Team of 8 to review any necessary documentation. The Team will only be reviewing the provisionally met standards. The Team will also need a tour of your facility.

Thank you for your cooperation,
Nicole Hall, Acting Administrative Officer

Claremore OK SVH Survey 3/9/10 – 3/11/10

51.210 a Administration – Not Met

No working policy being followed for thickened liquids. Based on observation, interview, and record review, it was determined that the facility failed to provide food in a form designed to meet individual needs for 8 sampled residents with orders for thickened liquids. Residents #2, #3, #10, #19, #20, #21, #23, #24, had physician orders for thickened liquids to prevent aspiration and choking. However, these residents, as well as 4 unsampled residents, Residents #31, #32, #33, and #34 were observed to receive thin liquids. The facility failed to assure that physician orders for thickened liquids were communicated by nursing and acted upon by dietary staff. The facility failed to follow manufacturers instructions in preparing thickened liquids, and was observed to present thin liquids to these 12 residents whose orders were for thickened liquids.

It was determined that an Immediate Jeopardy existed upon conclusion of the breakfast meal on 03/11/10. The facility was notified of the findings. The facility administrative staff provided a corrective action plan to remove the Jeopardy prior to service of the noon meal on 03/11/10. Observation of the noon meal on 03/11/10 revealed that the corrective action plan was successfully executed and the Jeopardy was abated. Observation of the dinner meal on 03/11/10 was also observed to confirm that the corrective action plan was in place.

Further findngs are noted in standard 51.140 d 3.

51.210 i Medical Director – Provisional Met

Though new medical director was appointed 3/1/2010, records and documentation reviewed show lack of significant involvement/participation of previous medical director. Per SVH facility description of position duties, the medical director is to hold regular medical staff meetings as well as show active involvement in other committees.

51.210 j Credentialing & Privileging – Provisional Met

Review of medical staff meeting minutes from April 2009 stated medical providers would receive, at minimum, education/in-services for ACLS during each medical staff meeting. There is no evidence this education was provided in medical staff meetings from April 2009 to date. Though staff are now certified in BLS, SVH facility communicated it would take action to provide ACLS education.

51.210 p 2 Quality Assessment and Assurance Committee – Not Met

Multiple instances of quality assessment and assurance issues not addressed in a comprehensive, coordinated approach by the committee. Facility staff identified to surveyors they were aware of problem with administration of thickened liquids, but there is no mention of this in QA committee minutes. Observations of surveyors during survey period conclude that other issues with physician orders, infection control tracking and trending, re-assessment of patients, and restraints are not being adequately addressed by the QA committee.

51.90 a Restraints – Provisional Met

Based on observation, interview, and record review, it was determined that the facility did not ensure that Resident #1 and Resident #11 were assessed for use of the least restrictive restraint. The facility failed to attempt restraint reduction to determine if the current restraint was appropriate for Resident #1 and Resident #11.

The findings include:

1. Resident #1 was admitted to the facility on 8/9/07 with diagnoses including dementia, depression, and hypertension. Observations of Resident #1 on 3/10/10 at 5:00 p.m. revealed resident reclined in a Geri chair with a pelvic restraint during the evening meal. On 3/11/10 at 12:00 p.m. and 5:00 p.m., Resident #1 was observed in the dining room reclined in a Geri chair with a pelvic restraint on.

A review of the medical record revealed a physician's order, dated 3/4/10, "Geri Chair with Pelvic restraint". A Physician's progress note, dated 3/4/10, which documented, "Resident would benefit from the positioning and safety aspect of the Geri chair and pelvic" following a fall from the resident's wheelchair. The progress note also documented "For the first time, nursing reports resident's wheelchair seat is broken down and may be why he has fallen forward out of it. Inspected the wheelchair seat and it looks like it is lax centrally and would not support his weight." A "Pre-Restraining Assessment", dated 3/11/10, documented, "Description of Behavior Indicating Possible Need for Restraint: leaning, poor balance and weakness. Recommendations for Restraint: Pelvic in Geri chair: trunk mattress.

In an interview with the Unit RN on 3/11/10 at 5:00 p.m., she stated, "The doctor wanted a pelvic restraint and a Geri chair because he (Resident #1) fell twice out of his wheelchair." When asked why they thought he would need a pelvic restraint while reclined in a Geri chair, she stated, "We think that if he sat up in the Geri chair-he would fall out of it. Sometimes we have him sitting upright." There were no observations of the resident sitting upright while in the Geri chair.

2. Observation of Resident #11 during the initial tour on 3/9/10 at 9 a.m. revealed Resident #11 sitting in a reclining Geri-chair with a pelvic restraint in place. An interview conducted on 3/9/10 with the staff tour guide revealed the resident had a history of falls and had been in a pelvic restraint for several months. Staff member was unsure if restraint reduction had been attempted. Record review revealed from 6/09 to 9/09 Resident #11 was ambulatory and had sustained numerous falls. Record review during this time revealed facility interventions included placing resident in low bed with floor mats. On 9/09 resident was placed in a rolling wheelchair with pelvic restraint and, the resident continued to sustain falls. In 10/09 the resident was placed in a Geri-chair with pelvic restraint. A review of the Safety Committee and Restraint Committee notes dated 12/2/09 and 2/18/10 revealed no attempts were made to reduce the pelvic restraint on this resident. An interview with the Assistant Director of Nursing on 3/11/10 at 4:30 p.m., revealed there were other least restrictive restraint devices that could have been utilized on this resident; and the interview confirmed the facility had not attempted restraint reduction.

F 221 S/S D

51.90 c 2 Abuse Investigating and Reporting – Provisional Met

Based on observation, interview, and record review, it was determined the facility did not assure alleged abuse was reported timely for an incident involving Resident #8 nor was an injury of unknown origin investigated for Resident #11. An employee was allowed to continue working during an ongoing investigation of physical abuse.

The findings include:

1. Review of the facility investigation revealed an incident of alleged abuse had taken place between Resident #8 and an employee who assists with care and resident transportation when needed. The alleged incident occurred on 02/01/10 while placing Resident #8 into a wheelchair from the bed. Resident #8 claimed in an interview with the facility that the employee pushed him into the wheelchair in such a rough manner, the resident sustained skin tears.

During an interview with the Administrator and the Director of Nursing on 03/10/10 at 2:45 p.m., it was determined that the facility scheduled the involved employee to attend an 8 hour dementia training class on 02/05/10 and was advised not to get in a hurry when getting residents up in the mornings. They stated the employee had worked at the facility for several years and was a good employee. Records revealed the employee was allowed to continue working at the facility. The investigation was concluded and determined there was no intent from the employee to harm Resident #8.

Further review of the investigation dated 02/10/10 revealed a phone call was received by the Director of Nursing at the facility. An outside source reported his daughter worked at the facility and there were numerous concerns the facility was allowing an "abuser" to continue working with the residents. On 02/10/10, the employee involved in the incident with Resident #8 was sent home and a report was sent to the department of Human Services. Another investigation was initiated on 2/12/10. The facility substantiated the allegation and currently has the employee on leave.

During an interview with the Administrator and the Director of Nursing on 03/10/10 at 2:45 p.m., it was confirmed that the investigation should have been acted upon in a timely manner and the alleged employee sent home during the investigation.

Review of the facility's policy on Patient Abuse, Neglect or Mistreatment revealed the Administrator or designee shall immediately suspend the accused employee with pay and initiate an investigation. The Administrator or designee shall report the incident to the Executive or designee within 12 hours.

2. An observation of Resident #11 on 3/10/10 at 9:45am revealed resident had a dark red raised area approximately 4.5 inches in length and 2.5 inches in width on her left lower leg and a purplish color area on the left hand middle finger. Interviews on 3/10/10 with the assigned Licensed Practical Nurse and Certified Nurse Aide revealed that both areas were new; the area on the left lower leg was discovered and reported to the nurse on 3/5/10. However the area on the left hand was never reported. Additional interviews with the staff members revealed the left leg injury was possibly caused by the resident hitting her leg on the side rails. An observation on 3/10/10 of the resident's bed with the staff members revealed the resident did not have side rails on the left side of the bed; staff members agreed the leg injury could not have resulted from the side rails. The facility was unable to provide incident reports for both injuries. A review of the facility's abuse policy revealed the component for investigation of injuries of unknown origin was not included. An interview with the Assistant Administrator on 3/11/10 revealed that incident reports for both injuries were not completed; the facility did not investigate injuries of unknown origin.

F 224 S/S=D

51.100 h 4 Social Service Crisis Intervention – Provisional Met

Based on interview and record review, it was determined that the facility failed to provide appropriate services and treatment to Resident #12 who displayed mental or psychosocial adjustment difficulties.

The findings include:

Resident #12 was admitted to the facility with diagnosis including PTSD (Post Traumatic Stress Disorder) and depression. A clinical record review revealed the resident had attempted suicide in the past. An additional record review of nurses' notes dated 12/19/09 resident stated that, "he would not be here much longer and wanted to see his brother one more time." At that time end of life issues were discussed with the nurse. Nurses notes dated 12/20/09 revealed resident again stated "he was ready to die" and nurses' notes dated 12/23/09 resident stated "wife should blow his brains out." Further reviews of nursing documentation in December revealed other episodes of resident wanting to end life.

A review of the MD/PA notes dated 12/19/09 revealed the physician considered a possible change of the resident's antidepressant medications and also have Social Services visit the resident about the concerns. A review of Social Services notes dated 1/21/10 revealed this was a second visit for the month of January and the resident seemed improved but still edgy. An additional review of the resident medical records revealed the Social Service Specialist failed to document the earlier January 2010 visit. Also documentation for the December episodes was not available.

An interview on 3/11/10 at 2 p.m. with the Social Services Specialist revealed that she was aware of the resident's diagnosis of depression, anxiety, and PTSD, but unaware of the past history of suicide attempts. The Social Service Specialist stated she had visited the resident during December but had not documented the visit. The Specialist also stated that she had been notified the resident was experiencing episodes of depression but was not aware that he was making statements of wanting to end his life. The Specialist agreed that given the resident's history, diagnosis, and recent statements that outside psychiatric services should have been considered to address his needs.

F 251 S/S=D

51.140 a – Annual assessment by the Registered Dietician – Provisional Met

Based on interview and record review, it was determined that the facility did not ensure that each resident had an annual nutritional assessment for 7(Resident #3,#6,#8,#11, #15, #16, #20) out of 30 sampled residents.

The findings include:

Resident #3 was admitted to the facility on 4/30/09. There was no evidence in the medical record of a nutritional assessment by a dietitian.

Resident #6 was admitted to the facility on 11/24/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

Resident #8 was admitted to the facility on 3/20/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

Resident #11 was admitted to the facility on 3/20/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

Resident #15 was admitted to the facility on 2/12/07. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

Resident #16 was admitted to the facility on 1/11/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

Resident #20 was admitted to the facility on 8/11/05. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

In an interview with the Assistant Foodservice Director on 3/10/10 at 5:30p.m., she stated, "I didn't realize I was supposed to refer annual reviews and admissions to the dietitian. I wasn't doing that."

F 275 S/S=E

51.140 d 3 Thickened Liquids – Not Met

Based on observation, interview, and record review, it was determined that the facility failed to provide food in a form designed to meet individual needs for 8 sampled residents with orders for thickened liquids. Residents #2, #3, #10, #19, #20, #21, #23, #24, had physician orders for thickened liquids to prevent aspiration and choking. However, these residents, as well as 4 unsampled residents, Residents #31, #32, #33, and #34 were observed to receive thin liquids. The facility failed to assure that physician orders for thickened liquids were communicated by nursing and acted upon by dietary staff. The facility failed to follow manufacturers instructions in preparing thickened liquids, and was observed to present thin liquids to these 12 residents whose orders were for thickened liquids.

It was determined that an Immediate Jeopardy existed upon conclusion of the breakfast meal on 03/11/10. The facility was notified of the findings. The facility administrative staff provided a corrective action plan to remove the Jeopardy prior to service of the noon meal on 03/11/10. Observation of the noon meal on 03/11/10 revealed that the corrective action plan was successfully executed and the Jeopardy was abated. Observation of the dinner meal on 03/11/10 was also observed to confirm that the corrective action plan was in place.

The findings include:

1. Observations of Resident #2 on 3/10/10 at 5:30 p.m. revealed the resident eating sherbet. Resident #2's diet card specified "nectar thick liquids".

Review of Resident #2's medical record revealed a Physician's order, dated 4/27/09, for "pureed diet, thick it to juice and liquids, patient chokes on thin liquids". The care plan, updated 2/10/10, listed under "problems", "chewing/swallowing difficulty due to diagnoses of dementia making a risk for aspiration". The care plan also listed under "approaches", "puree with thickened liquids".

2. Observation of Resident #3 on 3/9/10 at 10:00 a.m. revealed that the resident had thin water at bedside and a carton of un- thickened "Enlive" at bedside. Observation of the noon meal on 3/10/10 at 12:00 p.m., revealed the diet card did not list thickened liquids as part of the diet order. Observation on 3/10/10 at 5:30 p.m. revealed the resident was given orange sherbet for dinner and un-thickened milk; the diet card did not list thickened liquids as part of the diet order. Observation of Resident #3 on 3/11/10 at 8:00 a.m. revealed the resident's diet card did not list thickened liquids as part of the diet.

Review of the medical record revealed Resident # 3 had a Physicians order, dated 2/1/10, for "pureed diet with thickened liquids." A Physicians progress note, dated 2/1/10, documented "Coughing while eating". A Physicians progress note, dated 2/8/10, documented, "...continues to have dysphagia", a note dated 2/11/10, "She is still having dysphagia."

3. Observation of Resident #10 on 3/11/10 at 7:30 a.m. revealed a staff member giving a bottle of Glucerna and carton of milk without thickener to the resident. Resident coughed and sputtered several times while drinking the Glucerna and milk; staff members did not intervene at this time.

4. Observation of Resident #19 during the morning meal on 03/11/10 at 6:30 a.m. on the IC East (dementia unit) revealed Resident #19 receiving liquids with the meal not prepared to the nectar-thick consistency as ordered by the physician. Resident #19 was observed during the meal to have difficulty in swallowing and had to be prompted by staff to drink and eat slowly.

Interview with the Certified Nurse Assistant (CNA) on 03/11/10 at 6:40 a.m. revealed the thinned liquid served to Resident #19 had been thickened incorrectly and the CNA was not sure about the difference between honey and nectar thickened liquids.

Interview with the Unit Medication Nurse on 03/11/10 at 6:50 a.m. who assisted residents with meals on the IC East dementia unit stated Resident #19 probably did not need to be on thickened liquids now and after the meal returned from IC West unit stating the thickened liquids had been discontinued. A Clinical record review did not

reveal any assessments or evaluations ordered for the discontinuation of the nectar-thickened liquids.

Observation of Resident #19's room revealed a pitcher of water that had been incorrectly mixed. The unit Certified Nurse Aide (CNA) and the Director of Nursing were present in the resident's room. The CNA had added too much thickener and the water in the pitcher had turned pudding thick. Interview with the CNA on 03/11/10 at 7:00 a.m. revealed she was not sure about how much thickener to use.

5. Observation of Resident #20 in the IC East (dementia unit) dining room on 03/11/10 at 6:45 a.m. revealed the resident receiving liquids that had not been thickened accurately as ordered by the physician. Resident #20 was observed to have some difficulty with eating and drinking. Resident #20 received thin liquids with the meal. Review of the clinical records revealed the resident was to receive nectar-thick liquids.

Observation of Resident #20's room on 3/11/10 at 7:10 a.m. revealed a pitcher of water that had been incorrectly mixed. The unit CNA and the Director of Nursing were present in the resident's room. The water in the pitcher was pudding thick in consistency.

6. Observation of Resident #21 on 3/11/10 at 7:55 a.m. revealed the resident received a pureed diet and the meal ticket indicated the resident was to receive nectar thickened liquids. The meal tray had thin milk and thin cranberry juice. The resident drank all liquids before the staff members added the thickener. A review of the clinical record revealed a physician order for nectar thick liquids.

7. Observation of Resident #23 on 3/11/10 at 7:44 a.m. in the 2B dining room revealed the resident received juice and milk which was not honey thickened as per physician order. Resident #23 brought a travel mug of water to the dining room. The water in the travel mug was thin. The Unit Manager was interviewed at 7:50 a.m. and acknowledged that the liquids on the tray and the water in the mug were not thickened to the proper consistency.

8. Observation of Resident #24 on 3/11/10 at 7:40 a.m. in the 2B dining room revealed the resident received juice, milk and water that were not honey thickened as per physician order. The resident was couching and having difficulty swallowing the liquids. A unit CNA in the dining room yelled out "hey, are you ok over there?" No intervention was attempted by the staff.

9. Observation of Resident #31 on 3/11/10 at 7:45 a.m. in the 2B dining room revealed that the resident was served a tray which contained juice, milk, and water that were not honey thickened as per physician order. The resident consumed all the liquids with no attempt by the staff to thicken the liquids.

10. Observation of Resident #32 on 3/11/10 at 7:45 a.m. in the 2B dining room revealed that the resident received a tray which contained juice and milk that were not honey thickened as per physician order. The unit CNA attempted to thicken the liquids however honey consistency was not achieved. The Unit Manager acknowledged that the consistency was not correct.

11. Observation of Resident #33 on 3/11/10 at 7:50 in the 2B dining room revealed that the resident received juice and milk which was not honey thickened as per physician order. A unit CNA added thickener and stated "what does honey look like". The CNA was unsure how much thickener to add.

12. Observation of Resident #34 on 3/11/10 at 7:55 in the 2B dining room revealed that the resident was served juice, milk, and water which was thicken to pudding consistency. The unit CNA acknowledged that the resident should have nectar thick and what was served was "way too thick".

In an interview with the Assistant Food Service Supervisor on 3/10/10 at 6:00 p.m., she stated, "I didn't realize the thickened liquids could not have sherbet. We have been giving it to them. I will change the diet card for the next meal to have thickened liquids on it."

In an interview with the Director of Nursing on 03/11/10 at 7:30 a.m., she revealed staff needed training on how to thicken liquids and she was not aware the staff did not understand how much was needed for the different consistencies.

In an interview with the Assistant Nursing Home Administrator on 3/11/10 at 9:00 a.m., it was revealed that there was no current policy in effect for "Thickened Liquids". She stated, "We realized there was a problem with thickened liquids and have written a new policy, but we haven't implemented it or in serviced anyone on it yet."

In an interview with the Food Service Supervisor on 3/11/10 at 9:00 a.m. he stated, "I didn't realize thickened liquids couldn't have sherbet or ice cream. We also give them jello when on the menu." The Food Service Supervisor was not able to find a policy documenting which foods were not allowed on a thickened liquids diet.

In an interview with the Medical Director on 3/11/10 at 2:00 p.m., he acknowledged that the current situation with the thickened liquids was a concern.

In an interview with the Speech Therapist on 3/11/10 at 5:00p.m., she stated, "Thickened liquids shouldn't have foods such as jello, ice cream, or sherbet. It turns into a regular thin liquid at room temperature." She acknowledged that residents receiving these foods could aspirate.

F 367 S/S=K

Department of Veterans Affairs	STATE HOME INSPE(	)N (S	lards - Nursing Home Care)	
INITIAL SURVEY	RE-SURVEY Annual Survey		DATE SURVEYED 3/9/10 - 3/11/10	*REPORTS CONTROL NUMBER* *EXEMPT*

NAME OF FACILITY *Street Address, City, County, State, Zip Code*

Claremore State Veterans Home

SURVEYED BY *(VHA Field Activity of Jurisdiction)*
IDepartment of Veterans Affairs 1011 Honor Heights DR, OK. 73104

SURVEYORS NAME AND CORRESPONDENCE SYMBOL

1. Lindsey Alig, JCMVAMC - Co Team Leader	6. Vince Williams, Ascellon - Surveyor	11.
2. Debra Gibbs-Allen, RN, Ascellon - Co Team Leader	7.	12.
3. Mike Hickman, Fiscal, JCMVAMC - Surveyor	8.	LEGEND: M=Met; P=Provisional Met; N=Not Met; NA=Not Applicable
4. Patricia Beckmann, RN, Ascellon - Surveyor	9.	
5. Jackie Muir, RD, Ascellon - Surveyor	10.	

STANDARDS FOR NURSING HOME CARE	CHOOSE ONE	EXPLANATORY STATEMENTS
§ 51.210 Administration A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. a. Governing body: 1. The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and 2. The governing body or State official with oversight for the facility appoints the administrator who is: i. Licensed by the State where licensing is required; and ii. Responsible for operations and management of the facility.	(N) Not Met M P N NA	No working policy being followed for thickened liquids. Based on observation, interview, and record review, it was determined that the facility failed to provide food in a form designed to meet individual needs for 8 sampled residents with orders for thickened liquids. Residents #2, #3, #10, #19, #20, #21, #23, #24, had physician orders for thickened liquids to prevent aspiration and choking. However, these residents, as well as 4 unsampled residents, Residents #31, #32, #33, and #34 were observed to receive thin liquids. The facility failed to assure that physician orders for thickened liquids were communicated by nursing and acted upon by dietary staff. The facility failed to follow manufacturers instructions in preparing thickened liquids, and was observed to present thin liquids to these 12 residents whose orders were for thickened liquids. It was determined that an Immediate Jeopardy existed upon conclusion of the breakfast meal on 03/11/10. The facility was notified of the findings. The facility administrative staff provided a corrective action plan to remove the Jeopardy prior to service of the noon meal on 03/11/10. Observation of the noon meal on 03/11/10 revealed that the corrective action plan was successfully executed and the Jeopardy was abated. Observation of the dinner meal on 03/11/10 was also observed to confirm that the corrective action plan was in place. Further findngs are noted in standard 51.140 d 3.

b. Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change: 1. The State agency and individual responsible for oversight of a State home facility. 2. The State home administrator; 3. The State employee responsible for oversight of the State home facility if a contractor operates the State home.	(M) MET M P N NA	No change.
C 7. Annual State Fire Marshall's report.	(M) MET M P N NA	Attached to hardcopy.
c. State official must sign four certificates 8. Annual certification from the responsible State agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A set forth at § 51.224);	(M) MET M P N NA	Attached to hardcopy.
9. Annual certification for Drug-free Workplace Act of 1988 (VA Form 10-0143 set forth at § 51.225);	(M) MET M P N NA	Attached to hardcopy.
10. Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144 set forth at § 51.226);	(M) MET M P N NA	Attached to hardcopy.
11. Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 27-10-0144A located at § 51.227);	(M) MET M P N NA	Attached to hardcopy.
d. Percentage of Veterans. The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veterans residents must be spouses of veterans or parents all of whose children died while serving in the armed forces of the Untied States.	(M) MET M P N NA	

e. Management Contract Facility. If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis.	(N/A) Not Applicable M P N NA	The state manages and operates the facility.
f. Licensure. The facility and facility management must comply with applicable State and local licensure laws.	(M) MET M P N NA	
g. Staffing qualifications: 1. The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements 2. Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	(M) MET M P N NA	
h. Use of Outside Resources: 1. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h) (2) of this section. 2. Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for: i. Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and ii. The timeliness of the service.	(M) MET M P N NA	
i. Medical Director: 1. The facility management must designate a primary care physician to serve as medical director. 2. The medical director is responsible for: i. Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services;	(P) Provisional Met M P N NA	Though new medical director was appointed 3/1/2010, records and documentation reviewed show lack of significant involvement/participation of previous medical director. Per SVH facility description of position duties, the medical director is to hold regular medical staff meetings as well as show active involvement in other committees.

ii. Directing and coordinating medical care in the facility; iii. Helping to arrange for continuous physician coverage to handle medial emergencies; iv. Reviewing the credentialing and privileging process; v. Participating in managing the environment by reviewing and evaluating incident reports or summarizes of incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and vi. Monitoring employees' health status and advising the administrator on employee health policies.	Re[illegible].o rating above	
j. Credentialing and privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologist, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. 1. The facility management must uniformly apply Credentialing criteria to licensed independent practitioners applying to provide resident care or treatment under the facility's care. 2. The facility management must verify and uniformly apply the following core criteria: Current licensures; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. 3. The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credential's file must indicate that these criteria are uniformly and individually applied. 4. The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility. 5. When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience.	(P) Provisional Met M P N NA	Review of medical staff meeting minutes from April 2009 stated medical providers would receive, at minimum, education/in-services for ACLS during each medical staff meeting. There is no evidence this education was provided in medical staff meetings from April 2009 to date. Though staff are now certified in BLS, SVH facility communicated it would take action to provide ACLS education.

6. The facility management systemically must asses whether individuals with clinical privileges act within the scope of privileges granted.	Refer to rating above	
k. Required training of nursing aides. 1. Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or a volunteer who provide such services without pay. 2. The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless: i. That individual is competent to provide nursing and nursing related services; and ii. That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State.	(M) MET M P N NA	
3. Registry verification. Before allowing an individual to serve as a nurse aide, facility management must receive registry verification that the individual has met competency evaluation requirements unless the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. 4. Multi-State registry verification. Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual.	(M) MET M P N NA	

5. Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. 6. Regular in-service education. The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must: i. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; ii. Address areas of weakness as determined in nurse aide's performance reviews and may address the special needs of residents as determined by the facility staff; and iii. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	(M) MET M P N NA	
l. Proficiency of nurse aides. The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	(M) MET M P N NA	
m. Level B Requirement Laboratory services. 1. The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services: i. If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services. ii. If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes and regulations. iii. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory	(M) MET M P N NA	CLIA#37D0662748; last inspection 11/29/2009.

must be certified in the appropriate specialties and subspecialties of services and meet certification standards, statutes, and regulations. iv. The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection. v. Such services must be available to the resident seven days a week, 24 hours a day. 2. The facility management must: i. Provide or obtain laboratory services only when ordered by the primary physician; ii. Promptly notify the primary physician of the findings; iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and iv. File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	See rating above Provide CLIA#/Report	
n. Radiology and other diagnostic services. 1. The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. i. If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations. ii. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations. iii. Radiologic and other diagnostic services must be available 24 hours a day, seven days a week. 2. The facility management must: i. Provide or obtain radiology and other diagnostic services only when ordered by the primary physician; ii. Promptly notify the primary physician of the findings; iii. Assist the resident in making transportation	(M) MET M P N NA	

arrangements to and from the source of service, if the resident needs assistance; and iv. File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.	See rating above	
o. Clinical Records. 1. The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are: i. Complete; ii. Accurately documented; iii. Readily accessible; and iv. Systematically organized.	(M) MET M P N NA	
2. Clinical records must be retained for: i. The period of time required by State law; or ii. Five years from the date of discharge when there is no requirement in the State law.	(M) MET M P N NA	
3. The facility management must safeguard clinical record information against loss, destruction, or unauthorized use;	(M) MET M P N NA	
4. The facility management must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by: i. Transfer to another health care institution; ii. Law; iii. Third party payment contract; or iv. The resident.	(M) MET M P N NA	
5. The Clinical record must contain: i. Sufficient information to identify the residents; ii. A record of the resident's assessments; iii. The plan of care and services provided; iv. The results of any pre-admission screening conducted by the State; and v. Progress notes.	(M) MET M P N NA	

p. Quality assessment and assurance. 1. Facility management must maintain a quality assessment and assurance committee consisting of: i. The director of nursing services; ii. A primary physician designated by the facility; and iii. At least three other members of the facility's staff.	(M) MET M P N NA	
2. The quality assessment and assurance committee: i. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii. Develops and implements appropriate plans of action to correct identified quality deficiencies; and	(N) Not Met M P N NA	Multiple instances of quality assessment and assurance issues not addressed in a comprehensive, coordinated approach by the committee. Facility staff identified to surveyors they were aware of problem with administration of thickened liquids, but there is no mention of this in QA committee minutes. Observations of surveyors during survey period conclude that other issues with physician orders, infection control tracking and trending, re-assessment of patients, and restraints are not being adequately addressed by the QA committee.
3. Identified quality deficiencies are corrected within an established time period.	(M) MET M P N NA	
q. Disaster and emergency preparedness. 1. The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	(M) MET M P N NA	
2. The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	(M) MET M P N NA	
r. Transfer agreement. 1. The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that: i. Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary physician; and ii. Medical and other information needed for care and	(M) MET M P N NA	

treatment of residents, and, when the transferring facilit deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the nursing home or the hospital, will be exchanged between the institutions. 2. The facility is considered to have a transfer agreement in effect if the facility has an agreement with a hospital sufficiently close to the facility to make transfer feasible.	See rating above	
u. Intermingling. A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.	(N/A) Not Applicable M P N NA	The facility only provides nursing home care.
§ 51.40 Monthly Payment. a. 1. VA will pay per diem monthly for nursing home care provided to an eligible veteran in a facility recognized as a State home for nursing home care. During Fiscal Year 2000, VA will pay the lesser of the following: i. one-half of the costs of the care for each day the veteran is in the facility, or ii. $50.55 for each day the veteran is in the facility.	(M) MET Refer to VA Fiscal Audit Report M P N NA	
2. Per diem will be paid only for the days that the veteran is a resident at the facility. For purposes of paying per diem, VA will consider a veteran to be a resident at the facility during each full day that the veteran is receiving care at the facility. VA will not deem the veteran to be a resident at the facility if the veteran is receiving care outside the State home facility at VA expense. Otherwise, VA will deem the veteran to be a Resident at the facility during any absence from the facility that last no more than 96 consecutive hours. This absence will be considered to have ended when the veteran returns as a resident if the veteran's stay is for at least a continuous 24-hour period.	(M) MET M P N NA	
b. Total per diem costs for an eligible veteran's nursing home care consist of those direct and indirect costs attributable to nursing home care at the facility divided by the total number of patients (veterans + non-veterans) at the nursing home. Note: Fiscal audit should review and validate the total per diem cost report on VA Form 10-5588 in column 14L.	(M) MET M P N NA	

§ 51.70 Resident Rights The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights: a. Exercise of rights. 1. The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights. 3. The resident has the right to freedom from chemical or physical restraint. 4. In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been determined incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	(M) MET M P N NA	
b. Notice of rights and services. 1. The facility management must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification must be made prior to or upon admission and periodically during the resident's stay. 2. The resident or his or her legal representative has the right: i. Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and ii. After receipt of his or her records for review, to purchase at a cost not to exceed the community	(M) MET M P N NA	

standard photocopies of the records or any portions of them upon request and with 2 working days advance notice to the facility management. 3. The resident has the right to be fully informed in language that he or she can understand of his or her total health status; 4. The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (b)(7) of this section; and 5. The facility management must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services to be billed to the resident. 6. The facility management must furnish a written description of legal rights which includes: i. A description of the manner of protecting personal funds, under paragraph (c) of this section; ii. A statement that the resident may file a complaint with the State (agency) concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. 7. The facility management must have written policies and procedures regarding advance directives (e.g., living wills). These requirements include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. If an individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility management is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to	S. rating above See rating above	

the individual directly at the appropriate time. 8. The facility management must inform each resident of the name and way of contacting the primary physician responsible for his or her care.	S. . ating above	
9. Notification of changes: i. Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention; B. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); C. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); D. A decision to transfer or discharge the resident from the facility as specified in § 51.80(a) of this part. ii. The facility management must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is: A. A change in room or roommate assignment as specified in § 51.100 (f)(2); or B. A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. iii. The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member.	(M) MET M P N NA	

c. Protection of resident funds. 1. The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility. 2. Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(6) of this section.	(M) MET M P N NA	
3. Deposit of funds. i. Funds in excess of $100. The facility management must deposit any resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) ii. Funds less than $100. The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.	(M) MET M P N NA	
4. Accounting and records. The facility management must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. i. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. ii. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	(M) MET M P N NA	
5. Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.	(M) MET M P N NA	

6. Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility.	(M) MET M P N NA	
d. Free Choice. The resident has the right to: 1. Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and 2. Unless determined incompetent or otherwise determined to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	(M) MET M P N NA	
e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 1. Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. 2. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; 3. The resident's right to refuse release of personal and clinical records does not apply when: i. The resident is transferred to another health care institution; or ii. Record release is required by law.	(M) MET M P N NA	

f. Grievances. A resident has the right to: 1. Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and 2. Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	(M) MET M P N NA	
g. Examination of survey results. A resident has the right to: 1. Examine the results of the most recent VA survey with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and 2. Receive information from agencies acting as clinical advocates, and be afforded the opportunity to contact these agencies.	(M) MET M P N NA	
h. Work. The resident has the right to: 1. Refuse to perform services for the facility; 2. Perform services for the facility, if he or she chooses, when: i. The facility has documented the need or desire for work in the plan of care; ii. The plan specifies the nature of the services performed and whether the services are voluntary or paid; iii. Compensation for paid services is at or above prevailing rates; and iv. The resident agrees to the work arrangement described in the plan of care.	(M) MET M P N NA	
i. Mail. The resident has the right to privacy in written communications, including the right to: 1. Send and promptly receive mail that is unopened; and 2. Have access to stationary, postage, and writing implements at the resident's own expense.	(M) MET M P N NA	

j. Access and visitation rights. 1. The resident has the right and the facility management must provide immediate access to any resident by the following: i. Any representative of the Under Secretary for Health; ii. Any representative of the State; iii. Physicians of the resident's choice; iv. The State long-term care ombudsman; v. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time; and vi. Others who are visiting subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time. 2. The facility management must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. 3. The facility management must allow representatives of the State Ombudsman Program, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, subject to State law.	(M) MET M P N NA	
k. Telephone. The resident has the right to reasonable access to use a telephone where calls can be made without being overheard.	(M) MET M P N NA	
l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	(M) MET M P N NA	
m. Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	(M) MET M P N NA	

n. Self-Administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe.	(M) MET M P N NA	
§ 51.80 Admission, transfer and discharge rights. a. Transfer and discharge: 1. Definition. Transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. 2. Transfer and discharge requirements. The facility management must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: i. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home; ii. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home; iii. The safety of individuals in the facility is endangered; iv. The health of individuals in the facility would otherwise be endangered; v. The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility; or vi. The nursing home ceases to operate.	(M) MET M P N NA	
3. Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (a)(2)(vi) of this section, the primary physician must document in the resident's clinical record.	(M) MET M P N NA	
4. Notice before transfer. Before a facility transfers or discharges a resident, the facility must: i. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.	(M) MET M P N NA	

ii. Record the reasons in the resident's clinical record; and iii. Include in the notice the items described in paragraph (a)(6) of this section.	See rating above	
5. Timing of the notice. i. The notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged, except when specified in paragraph (a)(5)(ii) of this section; ii. Notice may be made as soon as practicable before transfer or discharge when: A. The safety of individuals in the facility would be endangered; B. The health of individuals in the facility would be otherwise endangered; C. The resident's health improves sufficiently so the resident no longer needs the services provided by the nursing home; D. The resident's needs cannot be met in the nursing home.	(M) MET M P N NA	
6. Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: i. The reason for transfer or discharge; ii. The effective date of transfer or discharge; iii. The location to which the resident is transferred or discharged; iv. A statement that the resident has the right to appeal the action to the State official designated by the State; and v. The name, address and telephone number of the State long term care ombudsman.	(M) MET M P N NA	
7. Orientation for transfer or discharge. A facility management must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	(M) MET M P N NA	

b. Notice of bed-hold policy and readmission. 1. Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility management must provide written information to the resident and a family member or legal representative that specifies: i. The duration of the facility's bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; and ii. The facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section permitting a resident to return. 2. Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. 3. Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room. If the resident requires the services provided by the facility.	(M) MET M P N NA	
c. Equal access to quality care. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.	(M) MET M P N NA	
d. Admissions policy. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract to pay the facility from the resident's income or resources.	(M) MET M P N NA	

§ 51.70 Resident behavior and facility practices. a. Restraints. 1. The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. i. Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. ii. Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. 2. The facility management uses a system to achieve a restraint-free environment. 3. The facility management collects data about the use of restraints. 4. When alternatives to the use of restraint are ineffective, restraint is safely and appropriately used.	(P) Provisional Met M P N NA	Based on observation, interview, and record review, it was determined that the facility did not ensure that Resident #1 and Resident #11 were assessed for use of the least restrictive restraint. The facility failed to attempt restraint reduction to determine if the current restraint was appropriate for Resident #1 and Resident #11. The findings include: 1. Resident #1 was admitted to the facility on 8/9/07 with diagnoses including dementia, depression, and hypertension. Observations of Resident #1 on 3/10/10 at 5:00 p.m. revealed resident reclined in a Geri chair with a pelvic restraint during the evening meal. On 3/11/10 at 12:00 p.m. and 5:00 p.m., Resident #1 was observed in the dining room reclined in a Geri chair with a pelvic restraint on. A review of the medical record revealed a physician's order, dated 3/4/10, "Geri Chair with Pelvic restraint". A Physician's progress note, dated 3/4/10, which documented, "Resident would benefit from the positioning and safety aspect of the Geri chair and pelvic" following a fall from the resident's wheelchair. The progress note also documented "For the first time, nursing reports resident's wheelchair seat is broken down and may be why he has fallen forward out of it. Inspected the wheelchair seat and it looks like it is lax centrally and would not support his weight." A "Pre-Restraining Assessment", dated 3/11/10, documented, "Description of Behavior Indicating Possible Need for Restraint: leaning, poor balance and weakness. Recommendations for Restraint: Pelvic in Geri chair: trunk mattress. In an interview with the Unit RN on 3/11/10 at 5:00 p.m., she stated, "The doctor wanted a pelvic restraint and a Geri chair because he (Resident #1) fell twice out of his wheelchair." When asked why they thought he would need a pelvic restraint while reclined in a Geri chair, she stated, "We think that if he sat up in the Geri chair-he would fall out of it. Sometimes we have him sitting upright." There were no observations of the resident sitting upright while in the Geri chair. 2. Observation of Resident #11 during the initial tour on 3/9/10 at 9 a.m. revealed Resident #11 sitting in a reclining Geri-chair with a pelvic restraint in place. An interview conducted on 3/9/10 with the staff tour guide revealed the resident had a history of falls and had been in a pelvic restraint for several months. Staff member was unsure if restraint reduction had been attempted. Record review revealed from 6/09 to 9/09 Resident #11 was ambulatory and had sustained numerous falls. Record review during this time revealed facility interventions included placing resident in low bed with floor mats. On 9/09 resident was placed in a rolling wheelchair with pelvic restraint and, the resident continued to sustain falls. In 10/09 the resident was placed in a Geri-chair with pelvic restraint. A review of the Safety Committee and Restraint Committee notes dated 12/2/09 and 2/18/10 revealed no attempts were made to reduce the pelvic restraint on this resident. An interview with the Assistant Director of Nursing on 3/11/10 at 4:30 p.m., revealed there were other least restrictive restraint devices that could have been utilized on this resident; and the interview confirmed the facility had not attempted restraint reduction.

§ 51.30 Resident behavior and facility practices. a. Restraints. 1. The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. i. Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. ii. Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. 2. The facility management uses a system to achieve a restraint-free environment. 3. The facility management collects data about the use of restraints. 4. When alternatives to the use of restraint are ineffective, restraint is safely and appropriately used.	(P) Provisional Met M P N NA	Based on observation, interview, and record review, it was determined that the facility did not ensure that Resident #1 and Resident #11 were assessed for use of the least restrictive restraint. The facility failed to attempt restraint reduction to determine if the current restraint was appropriate for Resident #1 and Resident #11. The findings include: 1. Resident #1 was admitted to the facility on 8/9/07 with diagnoses including dementia, depression, and hypertension. Observations of Resident #1 on 3/10/10 at 5:00 p.m. revealed resident reclined in a Geri chair with a pelvic restraint during the evening meal. On 3/11/10 at 12:00 p.m. and 5:00 p.m., Resident #1 was observed in the dining room reclined in a Geri chair with a pelvic restraint on. A review of the medical record revealed a physician's order, dated 3/4/10, "Geri Chair with Pelvic restraint". A Physician's progress note, dated 3/4/10, which documented, "Resident would benefit from the positioning and safety aspect of the Geri chair and pelvic" following a fall from the resident's wheelchair. The progress note also documented "For the first time, nursing reports resident's wheelchair seat is broken down and may be why he has fallen forward out of it. Inspected the wheelchair seat and it looks like it is lax centrally and would not support his weight." A "Pre-Restraining Assessment", dated 3/11/10, documented, "Description of Behavior Indicating Possible Need for Restraint: leaning, poor balance and weakness. Recommendations for Restraint: Pelvic in Geri chair: trunk mattress. In an interview with the Unit RN on 3/11/10 at 5:00 p.m., she stated, "The doctor wanted a pelvic restraint and a Geri chair because he (Resident #1) fell twice out of his wheelchair." When asked why they thought he would need a pelvic restraint while reclined in a Geri chair, she stated, "We think that if he sat up in the Geri chair-he would fall out of it. Sometimes we have him sitting upright." There were no observations of the resident sitting upright while in the Geri chair. 2. Observation of Resident #11 during the initial tour on 3/9/10 at 9 a.m. revealed Resident #11 sitting in a reclining Geri-chair with a pelvic restraint in place. An interview conducted on 3/9/10 with the staff tour guide revealed the resident had a history of falls and had been in a pelvic restraint for several months. Staff member was unsure if restraint reduction had been attempted. Record review revealed from 6/09 to 9/09 Resident #11 was ambulatory and had sustained numerous falls. Record review during this time revealed facility interventions included placing resident in low bed with floor mats. On 9/09 resident was placed in a rolling wheelchair with pelvic restraint and, the resident continued to sustain falls. In 10/09 the resident was placed in a Geri-chair with pelvic restraint. A review of the Safety Committee and Restraint Committee notes dated 12/2/09 and 2/18/10 revealed no attempts were made to reduce the pelvic restraint on this resident. An interview with the Assistant Director of Nursing on 3/11/10 at 4:30 p.m., revealed there were other least restrictive restraint devices that could have been utilized on this resident; and the interview confirmed the facility had not attempted restraint reduction.

		F 221 S/S D
b. Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. 1. Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. 2. Physical abuse includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment. 3. Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. 4. Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include	(M) MET M P N NA	
placing the individual in unsafe or unsupervised conditions. 5. Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative.	See rating above	
c. Staff treatment of residents. The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility management must: i. Not employ individuals who: A. Have been found guilty of abusing, neglecting, or mistreating individuals by a court of law; or B. Have had a finding entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of their property; and ii. Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	(P) Provisional Met M P N NA	Based on observation, interview, and record review, it was determined the facility did not assure alleged abuse was reported timely for an incident involving Resident #8 nor was an injury of unknown origin investigated for Resident #11. An employee was allowed to continue working during an ongoing investigation of physical abuse. The findings include: 1. Review of the facility investigation revealed an incident of alleged abuse had taken place between Resident #8 and an employee who assists with care and resident transportation when needed. The alleged incident occurred on 02/01/10 while placing Resident #8 into a wheelchair from the bed. Resident #8 claimed in an interview with the facility that the employee pushed him into the wheelchair in such a rough manner, the resident sustained skin tears. During an interview with the Administrator and the Director of Nursing on 03/10/10 at 2:45 p.m., it was determined that the facility scheduled the involved employee to attend an 8 hour dementia training class on 02/05/10 and was advised not to get in a hurry when getting residents up in the mornings. They stated the employee had worked at the facility for several years and was a good employee. Records revealed the employee was allowed to continue working at the facility. The investigation was concluded and determined there was no intent from the employee to harm Resident #8.

2. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. 3. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 4. The results of all investigations must be reported to the administrator or the designated representative and to other officials in accordance with State law within 5 working days of the incident, and appropriate corrective action must be taken if the alleged violation is verified.		Further review of the investigation dated 02/10/10 revealed a phone call was received by the Director of Nursing at the facility. An outside source reported his daughter worked at the facility and there were numerous concerns the facility was allowing an "abuser" to continue working with the residents. On 02/10/10, the employee involved in the incident with Resident #8 was sent home and a report was sent to the department of Human Services. Another investigation was initiated on 2/12/10. The facility substantiated the allegation and currently has the employee on leave. During an interview with the Administrator and the Director of Nursing on 03/10/10 at 2:45 p.m., it was confirmed that the investigation should have been acted upon in a timely manner and the alleged employee sent home during the investigation. Review of the facility's policy on Patient Abuse, Neglect or Mistreatment revealed the Administrator or designee shall immediately suspend the accused employee with pay and initiate an investigation. The Administrator or designee shall report the incident to the Executive or designee within 12 hours. 2. An observation of Resident #11 on 3/10/10 at 9:45am revealed resident had a dark red raised area approximately 4.5 inches in length and 2.5 inches in width on her left lower leg and a purplish color area on the left hand middle finger. Interviews on 3/10/10 with the assigned Licensed Practical Nurse and Certified Nurse Aide revealed that both areas were new; the area on the left lower leg was discovered and reported to the nurse on 3/5/10. However the area on the left hand was never reported. Additional interviews with the staff members revealed the left leg injury was possibly caused by the resident hitting her leg on the side rails. An observation on 3/10/10 of the resident's bed with the staff members revealed the resident did not have side rails on the left side of the bed; staff members agreed the leg injury could not have resulted from the side rails. The facility was unable to provide incident reports for both injuries. A review of the facility's abuse policy revealed the component for investigation of injuries of unknown origin was not included. An interview with the Assistant Administrator on 3/11/10 revealed that incident reports for both injuries were not completed; the facility did not investigate injuries of unknown origin. F 224 S/S=D
§ 51.100 Quality of Life. A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. a. Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	(M) MET M P N NA	

b. Self-determination and participation. The resident has the right to: 1. Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans for care; 2. Interact with members of the community both inside and outside the facility; and 3. Make choices about aspects of his or her life in the facility that are significant to the resident.		
c. Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.	(M) MET M P N NA	
d. Participation in resident and family groups. 1. A resident has the right to organize and participate in resident groups in the facility; 2. A resident's family has the right to meet in the facility with the families of other residents in the facility; 3. The facility management must provide the council and any resident or family group that exists with private space; 4. Staff or visitors may attend meetings at the group's invitation;	(M) MET M P N NA	
5. The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; 6. The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care	See rating above	

and life in the facility.		
e. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religious counseling by clergy of various faith groups.	(M) MET M P N NA	
f. Accommodation of needs. A resident has the right to: 1. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and 2. Receive notice before the resident's room or roommate in the facility is changed.	(M) MET M P N NA	
g. Patient activities. 1. The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	(M) MET M P N NA	
2. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who: - Is licensed or registered, if applicable, by the State in which practicing; and - Is certified as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body.	(M) MET M P N NA	
h. Social Services. 1. The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well being of each resident;	(M) MET M P N NA	
2. A nursing home with 100 or more beds must employ a qualified social worker on a full-time basis;	(M) MET M P N NA	

		F 251 S/S=D
5. Facilities for social services must ensure privacy for interviews.	(M) MET M P N NA	
i. Environment. The facility management must provide: 1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;	(M) MET M P N NA	
2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	(M) MET M P N NA	
3. Clean bed and bath linens that are in good condition;	(M) MET M P N NA	
4. Private closet space in each resident room, as specified in § 51.200 (d)(2)(iv) of this part;	(M) MET M P N NA	
5. Adequate and comfortable lighting levels in all areas;	(M) MET M P N NA	
6. Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees F.; and	(M) MET M P N NA	
7. For the maintenance of comfortable sound levels.	(M) MET M P N NA	
§ 51.110 Resident assessment. The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. a. Admission orders. At the time each resident is admitted, the facility management must have physician orders for the	(M) MET M P N NA	

resident's immediate care and a medial assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.		
b. Comprehensive assessments. 1. The facility management must make a comprehensive assessment of a resident's needs; i. Using the Health Care Financing Administration Long Term Care Resident Assessment Instrument Version 2.0; and ii. Describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity. iii. All nursing homes must be in compliance with this standard by no later than January 1, 2000.	(M) MET M P N NA	
2. Frequency. Assessments must be conducted: i. No later than 14 days after the date of admission; ii. Promptly after a significant change in the resident's physical, mental, or social condition; and iii. In no case less often than once every 12 months.	(M) MET M P N NA	
3. Review of Assessments. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	(M) MET M P N NA	
4. Use. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.	(M) MET M P N NA	
c. Accuracy of assessments. 1. Coordination. i. Each assessment must be conducted or coordinated with the appropriate participation of health professionals.	(M) MET M P N NA	

ii. Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. 2. Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.		
d. Comprehensive care plans. 1. The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: i. The services that are to be furnished to attain or maintain the resident's highest practicable physical,	(M) MET M P N NA	
mental, and psychosocial well-being as required under § 51.120; and ii. Any services that would otherwise be required under § 51.120 of this part but are not provided due to the resident's exercise of rights under § 51.70, including the right to refuse treatment under § 51.70(b)(4) of this part.	See rating above	
2. A comprehensive care plan must be: i. Developed within 7 calendar days after completion of the comprehensive assessment; ii. Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and iii. Periodically reviewed and revised by a team of qualified persons after each assessment.	(M) MET M P N NA	
3. The services provided or arranged by the facility must: i. Meet professional standards of quality; and	(M) MET	

ii. Be provided by qualified persons in accordance with each resident's written plan of care.	M P N NA	
e. Discharge summary. Prior to discharging a resident, the facility management must prepare a discharge summary that includes: 1. A recapitulation of the resident's stay; 2. A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and 3. A post discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	(M) MET M P N NA	
§ 51.120 Quality of care. Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. a. Reporting of Sentinel Events: 1. Definition. A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function. 2. Examples of sentinel events are as follows: i. Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or ii. Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or iii. Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or iv. Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or v. Assault, homicide or other crime resulting in patient death or major permanent loss of function; or	(M) MET M P N NA	

vi. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall. 3. The facility management must report sentinel events to the director of the VA medical center of jurisdiction within 24 hours of identification.		
4. The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. i. Goal. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.	(M) MET M P N NA	
b. Activities of daily living. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to: i. Bathe, dress, and groom; ii. Transfer and ambulate; iii. Toilet; iv. Eat; and v. Talk or otherwise communicate.	(M) MET M P N NA	
2. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and	(M) MET M P N NA	
3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.	(M) MET M P N NA	
c. Vision and hearing. To ensure that residents receive proper	(M) MET	

treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	M P N NA	
d. Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	(M) MET M P N NA	
e. Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that: 1. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and 2. A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	(M) MET M P N NA	
3. A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.	(M) MET M P N NA	
f. Range of motion. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition	(M) MET M P N NA	

demonstrates that a reduction in range of motion is unavoidable; and 2. A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.		
g. Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.	(M) MET M P N NA	
h. Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings were	(M) MET M P N NA	
unavoidable; and 2. A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.	See rating above	
i. Accidents. The facility management must ensure that: 1. The resident environment remains as free of accident hazards as is possible; and 2. Each resident receives adequate supervision and assistance devices to prevent accidents.	(M) MET M P N NA	
j. Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident: 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 2. Receives a therapeutic diet when a nutritional deficiency is identified.	(M) MET M P N NA	

k. Hydration. The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health.	(M) MET M P N NA	
l. Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: 1. Injections; 2. Parenteral and enteral fluids; 3. Colostomy, ureterostomy, or ileostomy care 4. Tracheostomy care; 5. Tracheal suctioning; 6. Respiratory care;	(M) MET M P N NA	
7. Foot care; and 8. Prostheses.	See rating above	
m. Unnecessary drugs: 1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: i. In excessive dose (including duplicate drug therapy); or ii. For excessive duration; or iii. Without adequate monitoring; or iv. Without adequate indications for its use; or v. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or vi. Any combinations of the reasons above.	(M) MET M P N NA	
2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility management must ensure that: i. Residents who have not used antipsychotic drugs are	(M) MET M P N NA	

not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and ii. Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		
n. Medication Errors. The facility management must ensure that: 1. Medication errors are identified and reviewed on a timely basis; and 2. Strategies for preventing medication errors and adverse reactions are implemented.	(M) MET M P N NA	
§ 51.130 Nursing Services. The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week. a. The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff.	(M) MET M P N NA	
b. The facility management must provide registered nurses 24 hours per day, 7 days per week.	(M) MET See staffing profile M P N NA	
c. The director of nursing services must designate a registered nurse as a supervising nurse for each tour of duty. 1. Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.	(M) MET M P N NA	

2. Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.		
d. The facility management must provide nursing services to ensure that there is a minimum direct care nurse staffing per patient per 24 hours, 7 days per week of no less than 2.5 hours.	(M) MET See staffing profile M P N NA	
e. Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part.	(M) MET M P N NA	
§ 51.140 Dietary Services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. a. Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis. 1. If a qualified dietitian is not employed full-time, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian. 2. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.	(P) Provisional Met M P N NA	Based on interview and record review, it was determined that the facility did not ensure that each resident had an annual nutritional assessment for 7(Resident #3,#6,#8,#11, #15, #16, #20) out of 30 sampled residents. The findings include: Resident #3 was admitted to the facility on 4/30/09. There was no evidence in the medical record of a nutritional assessment by a dietitian. Resident #6 was admitted to the facility on 11/24/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #8 was admitted to the facility on 3/20/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #11 was admitted to the facility on 3/20/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #15 was admitted to the facility on 2/12/07. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #16 was admitted to the facility on 1/11/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

2. Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.		
d. The facility management must provide nursing services to ensure that there is a minimum direct care nurse staffing per patient per 24 hours, 7 days per week of no less than 2.5 hours.	(M) MET See staffing profile M P N NA	
e. Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part.	(M) MET M P N NA	
§ 51.140 Dietary Services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. a. Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis. 1. If a qualified dietitian is not employed full-time, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian. 2. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.	(P) Provisional Met M P N NA	Based on interview and record review, it was determined that the facility did not ensure that each resident had an annual nutritional assessment for 7(Resident #3,#6,#8,#11, #15, #16, #20) out of 30 sampled residents. The findings include: Resident #3 was admitted to the facility on 4/30/09. There was no evidence in the medical record of a nutritional assessment by a dietitian. Resident #6 was admitted to the facility on 11/24/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #8 was admitted to the facility on 3/20/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #11 was admitted to the facility on 3/20/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #15 was admitted to the facility on 2/12/07. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year. Resident #16 was admitted to the facility on 1/11/08. There was no evidence in the medical record of a nutritional assessment by a dietitian in the past year.

		Resident #20 was admitted to the facility on 8/11/05. There no evidence in the medical record of a nutritional assessment by a dietitian the past year. In an interview with the Assistant Foodservice Director on 3/10/10 at 5:30p.m., she stated, "I didn't realize I was supposed to refer annual reviews and admissions to the dietitian. I wasn't doing that." F 275 S/S=E
b. Sufficient staff. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service.	(M) MET M P N NA	
c. Menus and nutritional adequacy. Menus must: 1. Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; 2. Be prepared in advance; and 3. Be followed.	(M) MET M P N NA	
d. Food. Each resident receives and the facility provides: 1. Food prepared by methods that conserve nutritive value, flavor, and appearance; 2. Food that is palatable, attractive, and at the proper temperature; 3. Food prepared in a form designed to meet individual needs; and 4. Substitutes offered of similar nutritive value to residents who refuse food served.	(N) Not Met M P N NA	Based on observation, interview, and record review, it was determined that the facility failed to provide food in a form designed to meet individual needs for 8 sampled residents with orders for thickened liquids. Residents #2, #3, #10, #19, #20, #21, #23, #24, had physician orders for thickened liquids to prevent aspiration and choking. However, these residents, as well as 4 unsampled residents, Residents #31, #32, #33, and #34 were observed to receive thin liquids. The facility failed to assure that physician orders for thickened liquids were communicated by nursing and acted upon by dietary staff. The facility failed to follow manufacturers instructions in preparing thickened liquids, and was observed to present thin liquids to these 12 residents whose orders were for thickened liquids. It was determined that an Immediate Jeopardy existed upon conclusion of the breakfast meal on 03/11/10. The facility was notified of the findings. The facility administrative staff provided a corrective action plan to remove the Jeopardy prior to service of the noon meal on 03/11/10. Observation of the noon meal on 03/11/10 revealed that the corrective action plan was successfully executed and the Jeopardy was abated. Observation of the dinner meal on 03/11/10 was also observed to confirm that the corrective action plan was in place. The findings include: 1. Observations of Resident #2 on 3/10/10 at 5:30 p.m. revealed the resident eating sherbet. Resident #2's diet card specified "nectar thick liquids". Review of Resident #2's medical record revealed a Physician's order, dated

4/27/09, for "pureed diet, thick it to juice and liquids, patie[illegible]kes on thin liquids". The care plan, updated 2/10/10, listed under "problems", "chewing/swallowing difficulty due to diagnoses of dementia making a risk for aspiration". The care plan also listed under "approaches", "puree with thickened liquids".

2. Observation of Resident #3 on 3/9/10 at 10:00 a.m. revealed that the resident had thin water at bedside and a carton of un- thickened "Enlive" at bedside. Observation of the noon meal on 3/10/10 at 12:00 p.m., revealed the diet card did not list thickened liquids as part of the diet order. Observation on 3/10/10 at 5:30 p.m. revealed the resident was given orange sherbet for dinner and un-thickened milk; the diet card did not list thickened liquids as part of the diet order. Observation of Resident #3 on 3/11/10 at 8:00 a.m. revealed the resident's diet card did not list thickened liquids as part of the diet.

Review of the medical record revealed Resident # 3 had a Physicians order, dated 2/1/10, for "pureed diet with thickened liquids." A Physicians progress note, dated 2/1/10, documented "Coughing while eating". A Physicians progress note, dated 2/8/10, documented, "...continues to have dysphagia", a note dated 2/11/10, "She is still having dysphagia."

3. Observation of Resident #10 on 3/11/10 at 7:30 a.m. revealed a staff member giving a bottle of Glucerna and carton of milk without thickener to the resident. Resident coughed and sputtered several times while drinking the Glucerna and milk; staff members did not intervene at this time.

4. Observation of Resident #19 during the morning meal on 03/11/10 at 6:30 a.m. on the IC East (dementia unit) revealed Resident #19 receiving liquids with the meal not prepared to the nectar-thick consistency as ordered by the physician. Resident #19 was observed during the meal to have difficulty in swallowing and had to be prompted by staff to drink and eat slowly.
Interview with the Certified Nurse Assistant (CNA) on 03/11/10 at 6:40 a.m. revealed the thinned liquid served to Resident #19 had been thickened incorrectly and the CNA was not sure about the difference between honey and nectar thickened liquids.

Interview with the Unit Medication Nurse on 03/11/10 at 6:50 a.m. who assisted residents with meals on the IC East dementia unit stated Resident #19 probably did not need to be on thickened liquids now and after the meal returned from IC West unit stating the thickened liquids had been discontinued. A Clinical record review did not reveal any assessments or evaluations ordered for the discontinuation of the nectar-thickened liquids.

Observation of Resident #19's room revealed a pitcher of water that had been incorrectly mixed. The unit Certified Nurse Aide (CNA) and the Director of Nursing were present in the resident's room. The CNA had added too much thickener and the water in the pitcher had turned pudding thick. Interview with the CNA on 03/11/10 at 7:00 a.m. revealed she was not sure about how much thickener to use.

5. Observation of Resident #20 in the IC East (dementia un[illegible]ing room on 03/11/10 at 6:45 a.m. revealed the resident receiving liqu[illegible]hat had not been thickened accurately as ordered by the physician. Resident #20 was observed to have some difficulty with eating and drinking. Resident #20 received thin liquids with the meal. Review of the clinical records revealed the resident was to receive nectar-thick liquids.

Observation of Resident #20's room on 3/11/10 at 7:10 a.m. revealed a pitcher of water that had been incorrectly mixed. The unit CNA and the Director of Nursing were present in the resident's room. The water in the pitcher was pudding thick in consistency.

6. Observation of Resident #21 on 3/11/10 at 7:55 a.m. revealed the resident received a pureed diet and the meal ticket indicated the resident was to receive nectar thickened liquids. The meal tray had thin milk and thin cranberry juice. The resident drank all liquids before the staff members added the thickener. A review of the clinical record revealed a physician order for nectar thick liquids.

7. Observation of Resident #23 on 3/11/10 at 7:44 a.m. in the 2B dining room revealed the resident received juice and milk which was not honey thickened as per physician order. Resident #23 brought a travel mug of water to the dining room. The water in the travel mug was thin. The Unit Manager was interviewed at 7:50 a.m. and acknowledged that the liquids on the tray and the water in the mug were not thickened to the proper consistency.

8. Observation of Resident #24 on 3/11/10 at 7:40 a.m. in the 2B dining room revealed the resident received juice, milk and water that were not honey thickened as per physician order. The resident was couching and having difficulty swallowing the liquids. A unit CNA in the dining room yelled out "hey, are you ok over there?" No intervention was attempted by the staff.

9. Observation of Resident #31 on 3/11/10 at 7:45 a.m. in the 2B dining room revealed that the resident was served a tray which contained juice, milk, and water that were not honey thickened as per physician order. The resident consumed all the liquids with no attempt by the staff to thicken the liquids.

10. Observation of Resident #32 on 3/11/10 at 7:45 a.m. in the 2B dining room revealed that the resident received a tray which contained juice and milk that were not honey thickened as per physician order. The unit CNA attempted to thicken the liquids however honey consistency was not achieved. The Unit Manager acknowledged that the consistency was not correct.

11. Observation of Resident #33 on 3/11/10 at 7:50 in the 2B dining room revealed that the resident received juice and milk which was not honey thickened as per physician order. A unit CNA added thickener and stated "what does honey look like". The CNA was unsure how much thickener to add.

		12. Observation of Resident #34 on 3/11/10 at 7:55 in the ning room revealed that the resident was served juice, milk, and water which was thicken to pudding consistency. The unit CNA acknowledged that the resident should have nectar thick and what was served was "way too thick". In an interview with the Assistant Food Service Supervisor on 3/10/10 at 6:00 p.m., she stated, "I didn't realize the thickened liquids could not have sherbet. We have been giving it to them. I will change the diet card for the next meal to have thickened liquids on it." In an interview with the Director of Nursing on 03/11/10 at 7:30 a.m., she revealed staff needed training on how to thicken liquids and she was not aware the staff did not understand how much was needed for the different consistencies. In an interview with the Assistant Nursing Home Administrator on 3/11/10 at 9:00 a.m., it was revealed that there was no current policy in effect for "Thickened Liquids". She stated, "We realized there was a problem with thickened liquids and have written a new policy, but we haven't implemented it or in serviced anyone on it yet." In an interview with the Food Service Supervisor on 3/11/10 at 9:00 a.m. he stated, "I didn't realize thickened liquids couldn't have sherbet or ice cream. We also give them jello when on the menu." The Food Service Supervisor was not able to find a policy documenting which foods were not allowed on a thickened liquids diet. In an interview with the Medical Director on 3/11/10 at 2:00 p.m., he acknowledged that the current situation with the thickened liquids was a concern. In an interview with the Speech Therapist on 3/11/10 at 5:00p.m., she stated, "Thickened liquids shouldn't have foods such as jello, ice cream, or sherbet. It turns into a regular thin liquid at room temperature." She acknowledged that residents receiving these foods could aspirate. F 367 S/S=K
e. Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician.	(M) MET M P N NA	
f. Frequency of meals. 1. Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. 2. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in paragraph (f)(4) of this section.	(M) MET M P N NA	

3. The facility staff must offer snacks at bedtime daily. 4. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day, if a resident group agrees to this meal span, and a nourishing snack is served.		
g. Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them.	(M) MET M P N NA	
h. Sanitary conditions. The facility must: 1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; 2. Store, prepare, distribute, and serve food under sanitary conditions; and 3. Dispose of garbage and refuse properly.	(M) MET M P N NA	
§ 51.150 Physician services. A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. a. Physician supervision. The facility management must ensure that: 1. The medical care of each resident is supervised by a primary care physician;	(M) MET M P N NA	
2. Each resident's medical record must list the name of the resident's primary physician; and 3. Another physician supervises the medical care of residents when their primary physician is unavailable.	See rating above	
b. Physician visits. The physician must: 1. Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; 2. Write, sign, and date progress notes at each visit; and	(M) MET M P N NA	

3. Sign and date all orders.		
c. Frequency of physician visits. 1. The resident must be seen by the primary physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or more frequently based on the condition of the resident. 2. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. 3. Except as provided in paragraphs (c) (4) of this section, all required physician visits must be made by the physician personally. 4. At the option of the physician, required visits in the facility after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.	(M) MET M P N NA	
d. Availability of physicians for emergency care. The facility management must provide or arrange for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency.	(M) MET M P N NA	
e. Physician delegation of tasks. 1. Except as specified in paragraph (e)(2) of this section, a primary physician may delegate tasks to: i. A certified physician assistant or a certified nurse practitioner; or ii. A clinical nurse specialist who: A. Is acting within the scope of practice as defined by State law; and B. Is under the supervision of the physician. Note: A certified clinical nurse specialist with experience in long term care is preferred.	(M) MET M P N NA	

2. The primary physician may not delegate a task when the regulations specify that the primary physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.	(M) MET M P N NA	
§ 51.160 Specialized rehabilitative services. a. Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must: 1. Provide the required services; or 2. Obtain the required services from an outside resource, in accordance with § 51.210(h) of this part, from a provider of specialized rehabilitative services.	(M) MET M P N NA	
b. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	(M) MET M P N NA	
§ 51.170 Dental Services. A facility: a. Must provide or obtain from an outside resource, in accordance with § 51.210 (h) of this part, routine and emergency dental services to meet the needs of each resident; b. May charge a resident an additional amount for routine and emergency dental services; c. Must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the dental services; and	(M) MET M P N NA	

3. Promptly refer residents with lost or damaged dentures to a dentist.		
§ 51.180 Pharmacy services. The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 51.210 (h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff.	(M) MET M P N NA	
a. Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	(M) MET M P N NA	
b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility; 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	(M) MET M P N NA	
c. Drug regimen review. 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 2. The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon.	(M) MET M P N NA	
d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	(M) MET M P N NA	

e. Storage of drugs and biologicals. 1. In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	(M) MET M P N NA	
2. The facility management must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse.	(M) MET M P N NA	
§ 51.190 Infection Control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. a. Infection control program. The facility management must establish an infection control program under which it: 1. Investigates, controls, and prevents infections in the facility; 2. Decides what procedures, such as isolation, should be applied to an individual resident; and	(M) MET M P N NA	

3. Maintains a record of incidents and corrective actions related to infections.		
b. Preventing spread of infection: 1. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. 2. The facility management must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. 3. The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	(M) MET M P N NA	
c. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	(M) MET M P N NA	
§ 51.200 Physical environment. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. a. Life safety from fire. The facility must meet the applicable provisions of the 1997 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference).	Refer to Life Safety Report	
b. Emergency power. 1. An emergency electrical power system must be provided	(M) MET	

to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. 2. The system must be the appropriate type essential electrical system in accordance with the requirement of NFPA 99, Health Care Facilities. 3. When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities. 4. The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources per NFPA 99, Health Care Facilities.	M P N NA	
c. Space and equipment. Facility management must: 1. Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and 2. Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	(M) MET M P N NA	
d. Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents: 1. Bedrooms must: i. **Accommodates no more than four residents;** ii. Measure at least 115 net square feet per resident in multiple resident bedrooms; iii. Measure at least 150 net square feet in single resident bedrooms; iv. Measure at least 245 net square feet in small double resident bedrooms; and v. Measure at least 305 net square feet in large double resident bedrooms used for spinal cord injury residents. It is recommended that the facility have	(M) MET **Existing home square Footage Review guidelines for Existing home and UFAS standards** M P N NA	

one large double resident bedroom for every 30 resident bedrooms. vi. Have direct access to an exit corridor; vii. Be designed or equipped to assure full visual privacy for each resident; viii. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; ix. Have at least one window to the outside; and x. Have a floor at or above grade level.		
2. The facility management must provide each resident with: i. A separate bed of proper size and height for the safety of the resident; ii. A clean, comfortable mattress; iii. Bedding appropriate to the weather and climate; and iv. Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	(M) MET M P N NA	
e. Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities. It is recommended that public toilet facilities be also located near the resident's dining and recreational areas.	(M) MET M P N NA	
f. Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from: 1. Resident rooms; and 2. Toilet and bathing facilities.	(M) MET M P N NA	
g. Dining and resident activities. The facility management must provide one or more rooms designated for resident dining and activities. These rooms must: 1. Be well lighted;	(M) MET M P N NA	

2. Be well ventilated; 3. Be adequately furnished; and 4. Have sufficient space to accommodate all activities.		
h. Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must: 1. Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	(M) MET M P N NA	
2. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;	(M) MET M P N NA	
3. Equip corridors with firmly secured handrails on each side; and	(M) MET M P N NA	
4. Maintain an effective pest control program so that the facility is free of pests and rodents.	(M) MET M P N NA	

STATE HOME INSPECTION				RCS 18-4
Claremore Veterans Center		DATE: 3/9/2010		
	HOSPITAL	NHC	DOM	TOTAL
OPERATING BEDS		302		302
BED CAPACITY APPROVALS (VA)		302		302
PATIENT CENSUS		298		298
POSITIONS AUTHORIZED		365		365
STAFF AVAILABLE		359		359
STAFF DISTRIBUTION				
	HOSPITAL	NHC	DOM	TOTAL
PHYSICIANS		3/2		2
PHYSICIANS ASSISTANT		2/2		2
DENTISTS		0		0
SOCIAL WORK msw		1/1		1
BSW		2/2		2
RADIOLOGY		1/1		1
LABORATORY		3/3		3
PHARMACY		2/2		2
PHARMACY TECH		1/1		1
CHOLOGY		0		0
AUDIOLOGY		0		0
NURSING		227/226		226
NURSING ADM/SUP		4/4		4
RN		16/10		10
LPN		50/48		48
NA		157/164		164
REHABILITATION THERAPY PT ASST.		1/1		1
REG P.T / PT AIDES		4/4		4
DIETETICS REG DIETITIAN		CONTRACT		CONTRACT
FOOD SUPERVISOR		3/3		3
DIETARY ASSISTANTS		34/36		36
ADMINISTRATIVE		18/15		15
MAINTENANCE		9/8		8
HOUSEKEEPING		27/26		26
LAUNDRY		13/13		13
RECREATION /ACTIVITIES		7/7		7
DIRECTOR		1/1		1/1
ASSISTANTS		6/6		6/6
VOLUNTEERS		100		100
FIRE & SAFETY		5/5		5

Nursing Service Staffing Pattern

HOSPITAL

SHIFT	SUN			MON				TUE		WED			THURS			FRI			SAT		
	RN	LPN	NA	RN	LPN	NA		LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

3.13 average hours of nursing care per patient per day

NURSING HOME

SHIFT	SUN			MON			TUE			WED			THURS			FRI			SAT		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY	2.75	8.25 2.5	27. 625	2.75	10.5 2	30. 1875	3.75	8.25 2.75	29. 8125	3.75	11.5 1.15	29. 1875	3.125	13.25 2	31. 25	2.75	10.5 1.5	37. 25	2.5	7.25 3.25	26. 9375
NING	1.75	9.25 3.25	27	2.5	9 2.5	26. 375	2.25	8.875 2.25	27.5	1.75	10 2.25	27.75	2.25	10 2	28. 875	2	9.375 2.25	29.25	2.25	8.25 3.75	27.75
NIGHT	2	11. 0625 .0625	17. 875	2	10. 6875	19. 875	2.5	10.375 .125	21. 0625	1.75	9 .0625	20	1	2.875	17. 5625	1.75	8.0625 .125	18. 5625	1.5	8.625 .125	17. 3125

DOMICILARY

SHIFT	SUN			MON				TUE		WED			THURS			FRI			SAT		
	RN	LPN	NA	RN	LPN	NA		LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF COMPLIANCE

LABORATORY NAME AND ADDRESS

OKLAHOMA VETERANS CENTER
3001 WEST BLUE STARR DRIVE
CLAREMORE, OK 74018

CLIA ID NUMBER
37D0662748

EFFECTIVE DATE
11/29/2009

LABORATORY DIRECTOR
SHIELA R BARRETT

EXPIRATION DATE
11/28/2011

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Judith A. Yost

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

172 certs2_010910

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)	EFFECTIVE DATE	LAB CERTIFICATION (CODE)	EFFECTIVE DATE
PARASITOLOGY (130)	10/09/2007		
ROUTINE CHEMISTRY (310)	11/29/1993		
URINALYSIS (320)	11/29/1993		
ENDOCRINOLOGY (330)	11/29/1995		
TOXICOLOGY (340)	11/29/1993		
HEMATOLOGY (400)	11/29/1997		

STATE OF OKLAHOMA OFFICE OF THE STATE FIRE MARSHAL 2401 NW 23rd Street, Suite 4 Oklahoma City, OK 73107 (405) 522-5005 Fax (405) 522-5028 INSPECTION FORM	Reviewed by _____ Sent to: _____ _____ _____ _____ $27.00 per/hr. Re-inspection fee charged for 0 hour	Required Fee (O.A.C. 265. Ch. 25 1-3) ☐ Check/M.O No. _____ Invoiced ☒ N/A ☐ Amount Received $ _____ Receipt # _____ ☒ Annual/Follow-up: No. Buildings: 1 x$20.00 ☐ Change of Use Analysis: $27.00/hr

Name of Facility	Claremore Veterans Center			File No.	J4935-060-10	Date	02/11/10
Address	3001 West Bluestar	City	Claremore	Zip	74017	County	Rogers
Phone	918-342-5432	Building Name	Claremore Veterans Center				
Owner	Claremore Veterans Center			Address	3001 West Bluestar		
City	Claremore	State	OK	Zip	74017	Phone	918-342-5432

Occupancy	I-2	No. of Buildings	1	Certificate of Occupancy Issued	Occupied		
Construction Type	2A	Area	195,000	Occupancy Load	302	Fire Alarm	Yes
Sprinkler	Yes						
Type Inspection:	Consultation ☐	Complaint ☐	Follow-up ☐	Special ☐	Annual ☒		
Construction 50% ☐	80% ☐	100% ☐	Sprinkler System 50% ☐	80% ☐	100% ☐	Fire Alarm 50% ☐	80% ☐ 100% ☐
No. of Stories	3	Basement	No	Last Fire Drill:	1/12/10	Last Inspected By:	D. Howard

Item No.	Comply Within	Code Reference	Deficiency / Violation
1		NFPA 72	Obtain a green tag for the fire alarm system.
2		NFPA 25 & 13	Obtain green tags for the Main Building and Auditorium riser.
3		NFPA 25 & 13	After discussion with inspector John McKnight, the sprinkler coverage in the corridor
		(W)	on the first floor and east of the reception area was installed according to the approved
			sprinkler plans by OSFM and shall not be altered or revised as identified on the recent
			fire sprinkler inspection. **If applicable, this issue may be presented to our variance committee.**
4		LSC 19.2.3.4	All obstructions and storage within all of the corridors shall be removed and a clear
			egress width shall be maintained by periodic in-house inspections.
5		NEC	Repair all leaks to prevent damage to electrical system and potentially igniting a fire.
6		19.1.1.4.1.2	Keep all fire barrier doors closed at all times, specifically the laundry room door.

I hereby acknowledge receipt of a copy of this inspection report; an exit interview and notice of correction will be given.

Name _____ Title _____

A Plan of Correction must be submitted to the State Fire Marshal's Office in Oklahoma City within 30 days, outlining the plan to correct any and all deficiencies.

Agent: D. Howard _____ Date: February 11, 2010

§ 58.14 VA Form 10–0143A—Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

STATEMENT OF ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Oklahoma Veterans Center, Claremore Division (hereinafter called the "Signatory")

(Name and location of State Veterans Home)

HEREBY AGREES THAT

It will comply with section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112) and all regulations adopted pursuant to such section, for instance, VA Regulations 7800 Series (38 CFR Section 18), to the end that no person in the United States shall, on the ground of handicap, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statues administered by the VA; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate the agreement.

If any real property or structure thereon is provided or improved with the aid of the Federal financial assistance extended to the Signatory by the VA, this assurance shall obligate the Signatory, or in the case of transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by the VA.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under Section 1741 of Title 38 USC. Federal financial assistance is understood to include benefits paid directly to the Signatory, and/or benefits paid to a beneficiary contingent upon such beneficiary being enrolled in a program offered by the Signatory.

The Signatory recognizes and agrees that such Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance, and that the VA will withhold financial assistance, facilities, or other benefits to ensure fulfillment of this assurance of compliance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Signatory, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance.

SIGNATURE OF AUTHORIZED OFFICIAL
Cynthia L Adam

TITLE
Administrator

DATE
7/7/09

MAILING ADDRESS
P.O. Box 988, Claremore, Ok 74018-0988

VA FORM 10-0143A SEP 1998 (R)

REPRODUCE LOCALLY

JetForm

§ 58.15 VA Form 10–0143—Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEES OTHER THAN INDIVIDUALS

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988, 38 CFR 44, Subpart F. The regulations, published in the January 31, 1989, Federal Register (pages 4950-4952) require certification by grantees, prior to award, that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the agency determines to award the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government-wide suspension or debarment (see CFR Part 44, Section 44.100 through 44.420).

The grantee certifies that it will provide a drug-free workplace by:

(1) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(2) Establishing a drug-free awareness program to inform employees about

(a) The dangers of drug abuse in the workplace;
(b) The grantee's policy of maintaining a drug-free workplace;
(c) Any available drug counseling, rehabilitation, and employee assistance programs; and
(d) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(3) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (1);

(4) Notifying the employee in the statement required by paragraph (1) that, as a condition of employment under the grant, the employee will

(a) Abide by the terms of the statement; and
(b) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(5) Notifying the agency within ten days after receiving notice under subparagraph (4) (b) from an employee or otherwise receiving actual notice of such convictions;

(6) Taking one of the following actions, within 30 days of receiving notice under subparagraph (4) (b), with respect to any employee who is so convicted;

(a) Taking appropriate personnel action against such employee, up to and including termination; or
(b) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(7) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (1), (2), (3), (4), (5) and (6).

VA FORM SEP 1998 (R) 10-0143 REPRODUCE LOCALLY JetForm

OMB Number: 2900-0188
Estimated Burden: 15 minutes

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEES OTHER THAN INDIVIDUALS

Places of Performance: The grantee shall insert in the space provided below the site(s) for performance of work done in connection with the specific grant (street address, city, county, state, zip code)

Oklahoma Veterans Center

3001 West Blue Starr Drive

Claremore, (Rogers) OK 74018-0988

ORGANIZATION NAME	GRANT NUMBER OR NAME
ODVA/Claremore Division	40-010
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Cynthia L. Adams, Administrator	
SIGNATURE	DATE
Cynthia L Adams	7/1/09

VA FORM SEP 1998 (F5) 10-0143 REPRODUCE LOCALLY JetForm

§ 58.16 VA Form 10–0144—Certification Regarding Lobbying.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

CERTIFICATION REGARDING LOBBYING

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

This certification is made in compliance with Section 319 of Public Law 101-121; and pursuant to the Interim Final guidance published as part VII of the December 20, 1989, Federal Register (Pages 57306-52332).

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certified, to the best of their knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Forms-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31 U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SIGNATURE OF CERTIFYING OFFICIAL	DATE
Cynthia L Adams	7/7/09
NAME AND TITLE OF CERTIFYING OFFICIAL	PROJECT (FAI NUMBER)
Cynthia L. Adams, Administrator	40-010
NAME AND ADDRESS OF STATE AGENCY ODVA/Claremore Division P.O. Box 988 Claremore, OK 74018-0988	

VA FORM SEP 1999 (R) 10-0144 REPRODUCE LOCALLY

§ 58.17 VA Form 10–0144A—Statement of Assurance of Compliance with Equal Opportunity Laws.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

STATEMENT OF ASSURANCE OF COMPLIANCE WITH EQUAL OPPORTUNITY LAWS

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Oklahoma Veterans Center/Claremore Division (hereinafter called the "Signatory")
(Name of Organization, Institution, or Individual)

HEREBY AGREES THAT:

It will comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), and all Federal regulations adopted to carry out such laws. This assurance is directed to the end that no person in the United States shall, on the ground of race, color, national origin (Title VI), handicap (Section 504), sex (Title IX, in education programs and activities only), or age (Age Discrimination Act) be excluded from participation in , be denied the benefits of, or be subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statutes administered by VA (Department of Veteran Affairs), the ED (Department of Education), or any other Federal agency. This assurance applies whether assistance is given directly to the recipient or indirectly through benefits paid to a student, trainee, or other beneficiary because of enrollment or participation in a program of the Signatory.

The Signatory HEREBY GIVES ASSURANCE that it will promptly take measures to effect this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Signatory or ED, this assurance shall obligate the Signatory, or in the case of transfer of such property any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases, this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by VA, ED or any other Federal agency.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under sections 104 and 244(1) of Title 38, U.S.C. Also, sections 1713, 1720, 1720A, 1741-1743, 2408, 5902(a)(2), 8131-8137, 8151-8156 (formerly 613, 620, 620A, 641-643, 1008, 3402(a)(2), 5031-5037, 5051-5056 respectively) and 38 U.S.C. chapters 30, 31, 32, 35, 36, 82, and 10 U.S.C. chapter 106. Under the terms of an agreement between VA and ED, this assurance also includes Federal financial assistance given by ED through programs administered by that agency. Federal financial assistance is understood to include benefits paid directly to the Signatory and/or benefits paid to a beneficiary contingent upon the beneficiary's enrollment in a program or using services offered by the Signatory.

The Signatory agrees that Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance; that VA or ED will withhold financial assistance, facilities, or other benefits to assure compliance with the equal opportunity laws; and that the United States shall have the right to seek judicial enforcement of this assurance.

THIS ASSURANCE is binding on the Signatory, its successors, transferees, and assignees for the period during which assistance is provided. The Signatory assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to its students or trainees in connection with the Signatory's programs or services are not discriminating against those students or trainees in violation of the above statutes.

SIGNATURE OF AUTHORIZED OFFICIAL	DATE
Cynthia L Adams	7/7/09

NAME AND TITLE OF AUTHORIZED OFFICIAL

Cynthia L. Adams, Administrator

MAILING ADDRESS OF AUTHORIZED OFFICIAL

P.O. Box 988
Claremore, OK 74018-0988

VA FORM APR 1998 (FI) 10-0144A

[FR Doc. 00–60 Filed 1–5–00; 8:45 am]
BILLING CODE 8320–01–C

Safety Inspection Report

Checklist for Existing Sprinkler-Protected Nursing Home Care Facilities
(All Code References are NFPA 101-2006 unless otherwise noted)

This checklist {current as of 02/2007} is a summation of the requirements found in Chapter 19, Existing Healthcare Occupancies of the Life Safety Code. This checklist is not intended to be comprehensive. The user is cautioned to consult the code prior to answering the following questions.

Facility Name: CLAREMORE VETERANS CENTER

Facility Address: 3001 W. BIVE STAR

State License No: and Expiration Date: WVC 2009 - 001 Exp: 12/19/2016

Date Inspected: Feb 9-11, 2010

See Below **

Item	Standard	Reference	Yes	No	N/A
	Building Construction				
1-1	Is the building containing the nursing home protected throughout by a fire sprinkler system? *Note: Nursing Homes under the State Home Per Diem Program are required to be sprinklered throughout, no later than August 13, 2013. This inspection report is intended for existing nursing homes that are sprinklered throughout in accordance with 19.3.5.1. For nursing homes that are not sprinklered throughout, this checklist does not fully address requirements for features such as, but not limited to, corridors, hazardous areas, and smoke barriers. Refer to Chapter 19 of NFPA 101.*	19.3.5.1	X		
1-2	Is emergency power available to operate all required electrical systems?	NFPA 99-2005 4.6.4.1.1.1	X		
1-3	Is emergency lighting provided throughout the means of egress?	19.2.9, 7.9.1.1	X		
1-4	Does the building construction meet the basic requirements of NFPA 101, paragraph 19-1.6.4?	19.1.6	X		
1-5	Are all hazardous areas (including boiler rooms, laundries, repair or repair shops, soiled linen rooms, storage rooms, trash rooms and laboratories) enclosed by smoke resisting partitions and self or automatic closing doors?	19.3.2.1	X		
1-6	Do all wall and ceiling finishes have a Class A or Class B flame spread rating (Class C is permitted within a room separated from exit access corridors in fully sprinkler protected buildings)?	19.3.3.2	X		
1-7	Do elevators, which have a travel distance of 25 feet or more, above or below the level that best serves emergency or fire fighting or rescue personnel equipped with automatic elevator (Phase I and II) recall?	9.4.3.2 ASME A17.3	X		
1-8	Are all receptacles of the grounding type?	NFPA 70-2005 210-7[a]	X		
1-9	Are there sufficient receptacles in the patient care areas so as to avoid the use of extension cords or multiple outlet devices?	NFPA 99-2005 4.3.2.2.6.2(a)-(d)	X		

Item	Standard	Reference	Yes	No	N/A
1-10	Are laundry chute openings into the corridors protected by 1-hour fire rated, self closing doors with approved and listed frames?	19.5.4.1			X
1-11	Are all exit stairs enclosed by one hour or greater rated construction for buildings 3 stories or less, or by 2 hour fire resistive construction where the exit connects 4 or more stories?	7.1.3.2.1	X		
1-12	Are all other vertical openings (shafts, chutes, elevator shafts, etc.) enclosed by 1 hour or greater rated construction?	19.3.1.1	X		
	Means of Egress - Arrangement				
2-1	Are exit stairs, which continue more than one-half story beyond the level of exit discharge interrupted at the level of exit discharge by partitions, doors, gates, or other effective means?	7.7.3	X		
2-2	Do all patient rooms have an outside window or door?	19.3.8	X		
2-3	Are all corridors serving patient sleeping rooms a minimum of 48 inches wide and kept free and clear of obstructions?	19.2.3.4 4.5.3.2	X		
2-4	Are projections into the corridor in compliance with the referenced section? (Alcohol hand rub dispensing units as well as other projections.)	19.2.3.4	X		
2-5	Are there two remote exits for each floor or fire/smoke area?	19.2.4.1	X		
2-6	Is corridor access compliant with the referenced section?	19.2.5.5	X		
2-7	Are suites in compliance with the referenced section?	19.2.5.6	X		
2-8	Does every corridor provide access to at least two approved exits without passing through any intervening rooms or spaces other than corridors or lobbies?	19.2.5.3	X		
2-9	Is the travel distance between any point in a patient sleeping room and the door to the room 50 feet or less?	19.2.6.2.5	X		
2-10	Are the means of egress properly marked with exit signage?	19.2.10	X		
	Means of Egress - Doors				
3-1	Are doors to hazardous areas equipped with self-closing or automatic closing devices and kept closed?	19.3.2.1.3	X		
3-2	Are exit stair enclosure doors and horizontal exit doors (if provided) self-closing and positive latching?	7.2.1.8 19.3.1.7	X		
3-3	Do exit access doors swing in the direction of exit travel when serving an occupant load of 50 or more?	7.2.1.4.2	X		
3-4	Are corridor doors equipped with a suitable means to keep the door closed when a force of 5 pounds is applied at the latch edge of the door? (Note required for rooms such as bathrooms that have no combustibles stored in them.)	19.3.6.3.5 19.3.6.3.6	X		
3-5	Area all doors in a means of egress at least 32 inches wide?	19.2.3.6	X		
3-6	Are doors within a means of egress equipped with hardware, which will open without the use of a key from the egress side except where the **clinical needs** of the patients require specialized security measures for their safety and provided the staff can readily unlock such doors at all time? (Locked & Alzheimer Wards)	19.2.2.2.4	X		

Item	Standard	Reference	Yes	No	N/A
3-7	Where doors are locked against egress for other than clinical reasons, do the locks meet the locking arrangements required for delayed-egress or access controlled locks in accordance with the referenced section?	7.2.1.6.1 7.2.1.6.2	X		
	Smoke Barriers				
4-1	Is each floor housing more than 30 patients divided into at least two smoke compartments?	19.3.7.1	X		
4-2	Is the maximum smoke compartment area 22,500 sq ft or less, and the travel distance to reach a smoke barrier door 200 feet or less?	19.3.7.1 (1)	X		
4-3	Are all doors smoke barriers self or automatic closing?	19.3.7.9	X		
4-4	Are smoke barrier substantial, such as 1-3/4 inch solid bonded wood core doors or equivalent and if they contain a vision panel, is it wired glass or fire rated glass in a steel frame?	19.3.7.7	X		
4-5	Is the clearance between meeting edges of smoke barrier doors limited to 1/8 inch or less?	19.3.7.4 A.8.5.4.1	X		
4-6	Are penetrations in smoke barrier walls properly sealed to resist the passage of smoke?	19.3.7.4 8.5.1	X		
	Protection - Sprinkler - Fire Alarm - Kitchen				
	Sprinkler System				
5-1	Are sprinkler systems electrically supervised by the fire alarm system?	19.3.5.3	X		
5-2	If provided, are laundry chutes provided with sprinkler protection at the top, bottom and every other floor between?	19.5.4.2 9.5 & 9.7			X
5-3	Are privacy curtains provided with mesh that has openings in the mesh equal to 70 percent or greater and extend a minimum of 22 in. from ceiling or are sprinklers located such that these curtains do not obstruct sprinkler discharge?	NFPA 13-2007 8.6.5.2.2.1	X		
5-4	Is a minimum of 18 inches clearance maintained between the top of all storage and ceiling sprinkler deflectors?	NFPA 13-2007 8.5.6.1	X		
	Fire Alarm System				
5-5	Are areas open to the corridor provided with direct staff supervision or provided with smoke detection connected to the fire alarm system?	19.3.6.1	X		
5-6	Is a manual fire alarm station provided in the natural path of egress near each required exit?	19.3.4.1 19.3.4.2, 9.6.3	X		
5-7	Are all manual fire alarm stations located so that the travel distance is no more than 200 feet, visible, unobstructed, and of the same general type?	9.6.2.4 9.6.2.5 9.6.2.6	X		
5-8	Is occupant notification accomplished automatically by means of an internal audible?	19.3.4.3.1 9.6.3.1	X		
	Kitchen Suppression				
5-9	Are grease producing appliances in the kitchen protected by an automatic fire suppression system?	NFPA 96-2004 10.1.2	X		
5-10	Does the operation of the kitchen automatic extinguishing system automatically shut off all sources of fuel and heat the equipment protected by the system?	NFPA 96-2004 10.4.1	X		

Item	Standard	Reference	Yes	No	N/A
5-11	Are shut down devices of the type that require manual resetting prior to fuel or power restoration?	NFPA 96-2004 10.4.3	X		
5-12	Is a readily accessible means available to manually activate the automatic extinguishing system?	NFPA 96-2004 10.5.1	X		
	General Maintenance				
6-1	Are doors and associated hardware in good repair?	4.6.12.1	X		
6-2	Is the means of egress (exit access, exits, exit discharge) free of any obstructions or impediments to full and instant use? This includes the accumulation of snow and ice.	7.1.10	X		
6-3	Are stairwells kept free of obstructions and storage?	7.1.3.2.3 7.2.2.5.3	X		
	Inspection and Testing Requirements				
7-1	For battery powered emergency lights, are they tested monthly for thirty (30) seconds and, are they functionally tested annually for not less than 1½ hours?	7.9.3	X		
7-2	Are sprinkler system main drain tests performed annually and are records maintained?	NFPA 25-2002 12.2.6	X		
7-3	Are sprinkler water flow alarms and valve supervisory tamper switches tested semi-annually?	NFPA 72-2007, Table 10.4.4 (15)	X		
7-4	Are fire pumps churn tested weekly and flow tested annually?	NFPA 25-2002 Table 8.1			N/A
7-5	Is the automatic fire extinguishing system protecting cooking equipment inspected and serviced by a properly trained and qualified company on at least a semiannual basis?	NFPA 96-2004 11.2.1	X		
7-6	Are hoods, grease removal devices, fans and ducts cleaned on a scheduled basis? *[Cleaning frequencies will vary depending upon use and the types of foods being prepared. Cleanings must be at least semiannual but more frequent cleanings may be required.]*	NFPA 96-2004 11.4.1	X		
7-7	If a generator set is utilized for emergency power, is it inspected weekly and tested under load, for at least 30 minutes, on a monthly basis?	NFPA 110-2005 8.3.2.1 & 8.4.1	X		
7-8	Are all receptacles in patient care areas tested for correct polarity and retention force (not less than 4 ounces) annually with documentation?	NFPA 99-2005 4.3.3.1.5 4.3.3.2.(1)-(4)	X		
7-9	Does the fire alarm system automatically transmit an alarm to the municipal fire department?	19.3.4.3.2	X		
7-10	Does documentation exist to show that the fire alarm system is tested in accordance with NFPA 72?	NFPA 72, 2007	X		
7-11	Does documentation exist showing that quarterly fire drills are conducted on all shifts and under varied conditions?	19.7.1.6	X		
7-12	Are fire extinguishers inspected every thirty (30) days and serviced annually?	NFPA 10-2007 7.2.1,	X		

Item	Standard	Reference	Yes	No	N/A
	Operational Features				
8-1	Does the facility have contingency plans to address the sprinkler system or fire alarms systems being out of service for more than 4 hours in a 24 hour period, such as evacuating the building or establishing a fire watch, prohibiting hot work, and notifying the fire department until the sprinkler system has been returned to service?	9.7.6.1	X		
8-2	Does the facility have a written fire safety plan that includes training of the staff?	19.7.2.2	X		
8-3	Does the facility has a smoking policy that addresses all items in the referenced standard?	19.7.4	X		
8-4	Are portable space heating devices prohibited in patient areas? If used only in non-sleeping staff and employee areas the heating elements of such devices do not exceed 100°C (212°F). ?	19.7.8	X		

**All answers are based upon visual inspection or information provided by the facility personnel to the inspector.

Recommended Corrective Actions:

Home (is) is not recommended for placement.

Inspected By: Vincent Williams

Approved By: _____

Department of Veterans Affairs

VHA FAX TRANSMITTAL

To	Fax Number ☐ FTS	☐ Commercial	Date	No. Pages Attached
Cindy Adams, Administrator Oklahoma Vet Center - Claremore	(918) 342-0835		09/08/2010	0

Subject

Follow-up VA Inspection

From	Telephone Number ☐ FTS	☐ Commercial
Nicole Hall, Acting Administrative Officer Jack C. Montgomery VA Medical Center		(918) 577-3830

This transmission is intended only for the use of the person or office to whom it is addressed and may contain information that is privileged, confidential, or protected by law.

All others are hereby notified that receipt of this fax does not waive any applicable privilege or exemption from disclosure and that any dissemination, distribution, or copying of this communication is prohibited.

If you received this communication in error, please notify us immediately at the telephone number shown above. Thank you.

CIRCLE ALL THAT APPLY 1. URGENT 2. FOR REVIEW 3. PLEASE COMMENT

4. PLEASE REPLY 5. PLEASE RECYCLE AFTER REVIEW

The VA will be conducting a follow-up inspection for your facility, Thursday, September 09, 2010, based on initial inspection conducted on March 11, 2010. The Team should begin to arrive at approximately 0930hrs. Please arrange for adequate space for the Team of 8 to review any necessary documentation. The Team will only be reviewing the provisionally met standards. The Team will also need a tour of your facility.

Thank you for your cooperation,
Nicole Hall, Acting Administrative Officer

OKLAHOMA VETERANS CENTER
CLAREMORE DIVISION
CLAREMORE, OK 74018

2010

VETERANS ADMINISTRATION INSPECTION RESPONSE
REVIEW DATE March 9, 10, & 11, 2010

PREPARED BY:
GLENDA DAVENPORT
ASSISTANT ADMINISTRATOR

VA Plan of Correction
Claremore Division
March 09, 2010 through March 11, 2010

STANDARD	DEFICIENCY	CORRECTIVE ACTIONS	EVIDENCE OF IMPROVEMENT	RESPONSIBLE PERSON	TARGET DATE
51.210(a)	**Not Met-Administration-**No working policy for thickened liquids. Further findings noted in standard 51.140 d 3.	Training has been provided to all nursing staff with continuing training as questions/issues arise concerning thickening of liquids. Pre-thickened water is provided at bedside for those residents who have orders for thickened liquids. Personal observation of proper preparation of thickened liquids is being performed by the Director of Nursing, Assistant Director of Nursing and Administration and issues or concerns addressed at that time with the staff.	Attachment 1-Policy Update, Purchase Order for Thickened Liquids for bedside and breakfast trays, and In-service sheets for staff.	Administration Nursing staff	March 11, 2010
51.210(i)	**Provisional Met-Medical Director-**Lack of involvement of previous medical director in holding regular medical staff meetings as well as active involvement in other committees.	A new Medical Director was appointed effective March 1, 2010. His responsibilities are outlined in policy and he is aware of his involvement in committees.	Attachment 2-Duties of the Medical Director Policy	G. Scott Jones, D.O. Medical Director	March 2010
51.210(j)	**Provisional Met-Credentialing and Privileging-**ACLS training not being provided in medical staff meetings from April 2009 to date.	ACLS education will be conducted at medical staff meetings and documented in the medical staff minutes. Staff receives BLS on a regular basis.	Attachment 3-Medical Staff Meeting Agenda	G. Scott Jones, D.O. Medical Director	April 2010
51.210(p)	**Not Met-Quality Assessment and Assurance Committee-**	Q.I. committee has reviewed activities and monitors and instituted new monitors to track	Attachment 4-QI Monitor restraints, pressure sores, & documentation.	Glenda Davenport, Asst. Administrator	April 2010

STANDARD	DEFICIENCY	CORRECTIVE ACTIONS	EVIDENCE OF IMPROVEMENT	RESPONSIBLE PERSON	TARGET DATE
	Instances of Quality assessment and Assurance issues not addressed in a comprehensive, coordinated approach by the committee.	restraints, pressure sores, and documentation.			
51.90(a)	**Provisional Met-Restraints-** Residents not assessed for use of the least restrictive restraint nor documentation to indicate if restraint reduction was attempted.	A Q.I. monitor has been instituted with a goal for reduction of restraints. Alternative methods have been reviewed. Dycem products have been purchased and being used as alternatives during current restraint reviews.	Attachment 5-QI Monitor Restraint Reduction	Glenda Davenport, Asst. Administrator	April 2010
51.90 (c) 2	**Provisional Met-Abuse Investigation & Reporting-** Facility did not assure alleged abuse was reported timely for an incident involving Resident # 8. Injury of unknown origin was not investigated for Resident # 11.	Facility policy has been revised	Attachment 6-Abuse Policy Revised	Cindy Adams, Administrator	March 2010
51.100 (h) 4	**Provisional Met-Social Service Crisis Intervention-** Facility failed to provide appropriate services and treatment to Resident #12 who displayed mental or psychosocial adjustment difficulties.	Residents will be referred to Social Services for consultation and recommendations for treatment. Resident # 12 was recommended to be sent for outside treatment options and refused to go. He was counseled by in-house staff.		Julia Alter, LCSW	April 2010
51.140 (a)	**Provisional Met-Annual Assessment by the Registered Dietitian-**Facility did not ensure that each resident had an annual nutritional assessment.	Annual nutrition assessments will be performed by the nutrition assistant and flagged for the Dietician for her review/recommendations. The dietician also performs	Attachment 7-QI Monitor for Annual Nutrition Assessments. Nutrition Note for Annual Assessment	Darlene Hibben, Nutrition Assistant	April 2010

STANDARD	DEFICIENCY	CORRECTIVE ACTIONS	EVIDENCE OF IMPROVEMENT	RESPONSIBLE PERSON	TARGET DATE
		assessments on all tube feeders, residents at nutritional risk, and all others as requested by the medical provider. QI Monitor has been set up to ensure annual nutrition assessments are completed.			
51.140 (d) 3	**Not Met-Thickened Liquids-** Facility failed to provide food in a form designed to meet individual needs for residents with orders for thickened liquids.	Training has been provided to all nursing staff with continuing training as questions/issues arise concerning thickening of liquids. Pre-thickened water has been ordered and placed at bedside for those residents who have orders for thickened liquids. Personal observation of proper preparation of thickened liquids is being performed by the Director of Nursing, Assistant Director of Nursing and Administration. Physician orders have been written as Additional Diet Orders to include consistency of liquids, and the dietary department added the consistency to the resident's diet card which is sent with the food trays to the units for staff awareness when serving meals/beverages. The dietary department has also added "no Jello, ice cream or sherbet" to the diet cards for the residents who have thickened liquids orders.	Attachment 8-Tray cards of residents with thickened liquids.	Darlene Hibben, Nutrition Assistant	April 2010

VA Plan of Correction
Claremore Division
March 09, 2010 through March 11, 2010

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